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ABSTRACT

This report addresses implementation of the maternal and child health (MCH) services block grant. Information concerning implementation was gathered from 13 states. At least one state was selected in every standard federal region, and, in total, the 13 states accounted for approximately 45 percent of all block grant funds and an equivalent portion of the nation's population. In addition, these states accounted for about 40 percent of MCH block grant funds. At the federal level, information concerning MCH fund allocations for fiscal years 1981, 1982, and 1983 and certain program information was obtained. At state and local levels, a wide variety of data collection instruments and approaches was used to obtain information from individuals or organizations responsible for or having an interest in a single block grant or multiple block grants. Fieldwork was carried out primarily between January and August of 1983. Chapters of the report focus on the following: funding patterns emerging under the MCH block grant and the ways they differed from patterns existing in prior categorical programs; changes made at the state and service-provider levels in the types of MCH services offered and the methods of delivery; state organization and management changes; and the involvement of citizens, state elected officials, and interest groups in processes leading to decisions on the use of block grant funds. Appendices describe data collection methodology, indicate expenditures for various health conditions, and disclose interest group responses to questions about block grant implementation for MCH programs. (RH)

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Maternal And Child Health Block Grant: Program Changes Emerging Under State Administration

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The Omnibus Budget Reconciliation Act of 1981 consolidated eight categorical programs into the maternal and child health services block grant and shifted primary administrative responsibility to states. States continued to support activities similar to those funded under the prior categorical programs although some changes were made to program priorities and services offered. States tended to assign higher priority and make fewer program changes in areas where they had considerable previous involvement.

The availability of prior categorical grant funds in 1982 mitigated the impact of reduced maternal and child health block grant funding and enabled states to reserve block grant funds for the next year. As categorical funds diminished, however, state and other sources of funds began shouldering a greater share of program costs. In 1983 the emergency jobs bill legislation substantially increased the maternal and child health appropriation and should help promote relatively stable funding in 1984.

States' health agencies were carrying out block grant responsibilities and management improvements were reported in some states. Various methods were used to obtain public input, and the involvement of state elected officials and interest groups had increased. Most state officials rated the block grant more flexible and desirable, while about half the interest groups responding preferred the prior categorical approach.

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COMPTROLLER GENERAL OF THE UNITED STATES
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To the President of the Senate and the
Speaker of the House of Representatives

Various committees of the Congress requested that the General Accounting Office review the implementation of the block grants created by the Omnibus Budget Reconciliation Act of 1981. The enclosed report provides comprehensive information concerning the progress states are making in implementing the maternal and child health services block grant. It is one of several reports we will issue on block grant implementation.

Copies of this report are being sent to the appropriate House and Senate Committees; the Secretary of Health and Human Services; the Director, Office of Management and Budget; and the Governors and legislatures of the states we visited.

Charles A. Bowsher

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

MATERNAL AND CHILD HEALTH BLOCK GRANT: PROGRAM CHANGES EMERGING UNDER STATE ADMINISTRATION

D I G E S T

The Omnibus Budget Reconciliation Act of 1981 substantially changed various federal domestic assistance programs by consolidating numerous federal categorical programs into several block grants and shifting primary administrative responsibility to states. This report focuses on one of those block grants--maternal and child health (MCH)--and is one of a series GAO will issue to give the Congress a status report on block grant implementation.

Reflecting their considerable involvement in administering the prior categorical programs, states GAO visited strived to maintain program continuity under the maternal and child health block grant, and most increased expenditures of state and other funds to help offset declining federal support. However, as states reassessed their needs and confronted limitations on available funds, they tended to maintain or increase broader programs, such as crippled children's services, while providing less support for certain more narrowly targeted activities, such as lead-based paint poisoning prevention, which were previously mandated or directly federally funded.

States generally assigned MCH block grant responsibilities to their state health agencies, resulting in limited organizational changes. Block grant management activities were often integrated with ongoing state efforts. Various methods were used to obtain public input, and the involvement of state elected officials and interest groups increased. Most state officials rated the block grant more flexible and desirable, whereas about half the interest groups expressed a preference for the prior categorical approach.

GAO did its work in 13 states: California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont, and Washington. Together these states receive 40 percent of the

national MCH block grant appropriations and account for about half of the nation's population. While these states represent a diverse cross-section, the results of GAO's work cannot be projected for the entire country. (See pp. 4 and 5.)

BLOCK GRANT MERGES FEDERAL PROGRAMS AND EXPANDS STATES' AUTHORITY

The federal government has helped fund services to mothers and children under title V of the Social Security Act since the 1930's when states were given broad authority to determine the use of funds. However, starting in the 1960's, the Congress mandated certain services and introduced several small, narrowly focused categorical programs that were primarily federally administered.

In 1981, the MCH block grant legislation consolidated eight categorical programs: crippled children's, maternal and child health, lead-based paint poisoning prevention, sudden infant death syndrome, adolescent pregnancy prevention, genetic disease testing and counseling, hemophilia diagnostic and treatment centers, and disabled children receiving supplemental security income benefits. The legislation expanded states' program and administrative responsibilities, except for a federally administered Secretary's set-aside fund.

The Congress appropriated $372 and $373 million for fiscal years 1982 and 1983, respectively. This represented an 18-percent reduction from the $455 million appropriation level in fiscal year 1981 for the eight categorical programs. In 1983, the MCH block grant appropriation was increased by $105 million through the emergency jobs bill legislation. State officials reported that the majority of these funds, however, will be spent in 1984 because they were received late in states' fiscal year 1983. These funds should allow relatively stable funding in 1984. (See p. 19.)

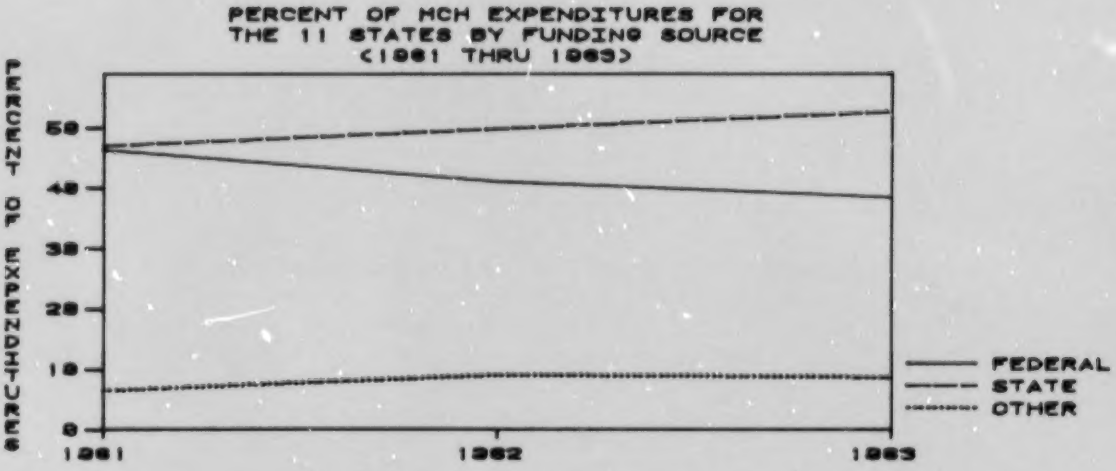
STATES ASSUME A LARGER SHARE OF MCH FUNDING

Because the MCH block grant is one of several funding sources for broader state health

programs, decisions on how to use MCH block grant funds are integrated into states' overall health planning and budgeting processes. Therefore, decisions are made in the context of the overall availability of funds from federal, state, and other sources. As a result, changes in the level of federal and state funding were important concerns in establishing program priorities and objectives, along with states' desire to assure program continuity and minimize disruption of services. (See pp. 9 and 26.)

Although federal allocations decreased as states began implementing the MCH block grant, total expenditures for all programs supported with block grant funds increased between 1981 and 1983 in 8 of the 11 states which had operated the block grant since October 1981. The increases ranged from 4 percent in Massachusetts to 42 percent in Vermont. Additionally, total expenditures increased between 1982 and 1983 in those two states which delayed block grant implementation until 1982. However, when total expenditures are adjusted by the inflation factor for state and local purchases of goods and services of about 7 percent a year over the 1981-83 period, only 5 of the 13 states experienced an increase in constant dollars, ranging from 4 percent in Florida to 24 percent in Vermont.

The availability of prior categorical funds during states' first year of block grant implementation mitigated the impact of federal funding reductions and enabled states to carry block grant funds into future years. As categorical outlays diminished in 1983, state and other sources of funds began shouldering a greater percentage of total MCH expenditures as shown below. (See pp. 11 to 19.)



STATES MOVING TO PUT THEIR IMPRINT ON MCH SERVICES

States generally have continued to support activities that were similar to those funded under the prior categorical programs as they emphasized the need to maintain program continuity. States, however, used their block grant flexibility to alter program priorities and some services offered. The scope and dimensions of the changes vary and have been influenced by the degree of administrative involvement states had under the prior programs. (See pp. 19 to 26.)

The states had considerable involvement in the prior crippled children's and maternal and child health categorical programs, which in 1981 accounted for 92 percent of the expenditures for programs consolidated into the block grant. These two program areas continued to receive the same share of total expenditures in 1983 and the types of services offered remained relatively unchanged. States, however, refocused aspects of each program area.

Crippled children's services continued to be a high priority program. Nine of the 13 states increased expenditures and none reported dropping any services. Moreover, eight states consolidated services for disabled children receiving supplemental security income benefits with their crippled children's program to eliminate what state officials believed to be duplicative services. (See pp. 28 to 32.)

Trends for maternal and child health services were more mixed, with expenditures increasing in seven states and declining in six. Much of the decrease occurred in the program of special projects, which states were previously required to provide. Twelve of 13 states reduced or eliminated support for these projects in part because similar services were available under broader state programs. Other service changes occurred, but they were not linked directly to block grant implementation. (See pp. 32 to 41.)

Under the MCH block grant, many states assumed new responsibilities for five smaller prior categorical programs, which together account for less than 8 percent of total expenditures. Between 1981 and 1983 expenditures decreased in 7 of the 8 states offering lead-based paint poisoning prevention activities and in 8 of 12 states reporting expenditures for sudden infant death syndrome services. While states' flexibility increased in the areas of adolescent pregnancy prevention, hemophilia, and genetic disease testing and counseling, a large percentage of total expenditures for these programs continued to come directly from the Secretary's set-aside fund. Moreover, trends among states in these areas varied widely. (See pp. 43 to 57.)

While the 13 states adjusted program priorities, the 44 service providers GAO visited to obtain some limited examples of operations at the local level experienced a variety of changes. Although certain changes were attributed directly to block grant implementation, many providers pointed to a diverse array of factors influencing their operations, such as escalating costs, changing sources of funds, prevailing economic conditions, and continuing reassessment of alternative ways to deliver services. (See pp. 36 to 41 and 48 to 57.)

STATES CARRY OUT PROGRAM MANAGEMENT RESPONSIBILITIES

States generally assigned MCH block grant responsibilities to their state health agencies and made only minimal changes to their organization or to the structure of the service provider network. States carried out their block grant management activities by establishing program requirements, monitoring grantees, providing technical assistance, collecting data, and auditing funds. These efforts were often integrated with ongoing state efforts for other state or federal programs. (See pp. 59 to 68.)

The block grant was accompanied by reduced federal administrative requirements and was expected to enable states to manage programs more efficiently and effectively. According to state officials, the block grant influenced 7 of the 13 states to change or standardize their administrative requirements, 8 to improve planning and budgeting, 6 to better use state personnel, and 6 to reduce the time and effort involved in reporting to the federal government. While there were some indications of administrative simplification, specific cost savings could not be quantified, and officials offered varying perceptions of changes in administrative costs under the block grant. (See pp. 68 to 75.)

INCREASED PUBLIC PARTICIPATION AND INVOLVEMENT OF STATE ELECTED OFFICIALS

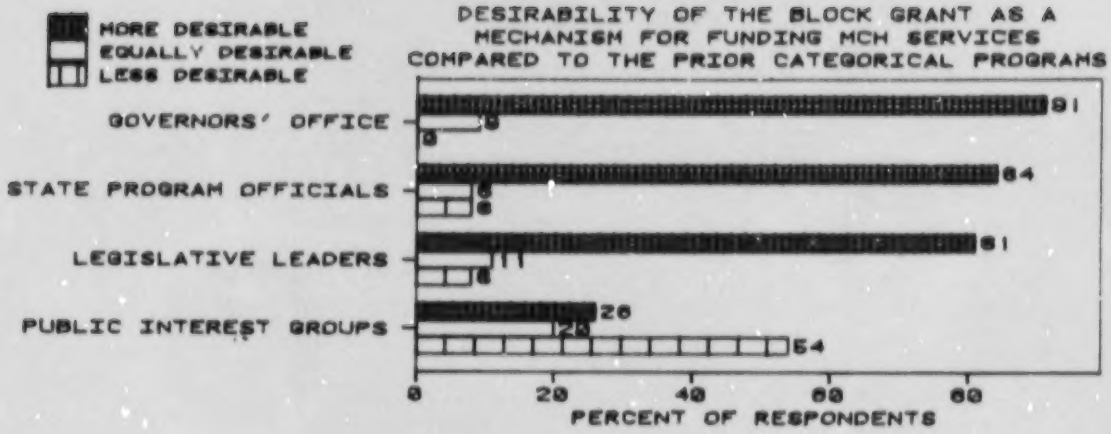
In addition to preparing required reports on the planned and actual use of MCH block grant funds and making them available for public comment, all 13 states reported holding public hearings, and 10 used one or more advisory groups. Many program officials reported that these latter sources of input, together with informal consultations, often had the most influence on program decisions.

State officials generally believed that levels of public participation were greater under the block grant than under the categorical programs. Also, program officials noted that governors and legislatures had become more involved in six states, usually through the state budget process. (See pp. 77 to 84.)

Interest group respondents across the 13 states were often satisfied with their access to state officials and the role and composition of advisory committees. Their views, however, were more mixed regarding public hearings and states' responsiveness to their concerns. Interest groups were evenly divided on their degree of satisfaction with state responses to the need to maintain or increase funds for specific services, but generally they were less satisfied with funding provided to specific geographic areas of the states. About half believed that changes states have made adversely affected individuals or organizations that they represent, whereas 28 percent viewed such changes favorably; the rest perceived no impact. (See pp. 84 to 87.)

OVERALL PERCEPTIONS OF BLOCK GRANTS DIFFER

As shown on the next page, state executive and legislative branch officials generally viewed the block grant approach to be more desirable than the prior categorical approach. In addition, they found the block grant increased flexibility and was less burdensome. Conversely, interest groups tended to view the block grant as less desirable. While interest groups and state officials had differing views, both expressed concern about the federal funding reductions that accompanied the block grant, which from their perspective tended to somewhat diminish its advantages. GAO believes, however, it was often difficult for individuals to separate block grants--the funding mechanism--from block grants--the budget-cutting mechanism. (See pp. 87 and 88.)



AGENCY COMMENTS

HHS officials commented that this report was an informative summary of the implementation of the MCH block grant. They stated that the report will be useful to the agency during their efforts to monitor the program. HHS officials provided oral comments which were limited to a few points of clarification and were considered in preparing this report.

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ABBREVIATIONS

GAO	General Accounting Office
HHS	Department of Health and Human Services
MCH	maternal and child health
SIDS	sudden infant death syndrome
SSI	supplemental security income

CHAPTER 1

INTRODUCTION

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) substantially changed the administration of various federal domestic assistance programs by consolidating numerous federal categorical programs into block grants and shifting primary administrative responsibility to the states. Of the nine block grants enacted, four relate to health services, two to social services, and one each to low income energy assistance, education, and community development.

The 1981 act gives states greater discretion, within certain legislated limitations, to determine programmatic needs, set priorities, allocate funds, and establish oversight mechanisms. Since the act was passed, the Congress, as well as the public and private sectors, has been greatly interested in how the states have exercised their additional discretion and what changes the block grant approach has brought about for services provided to the people. In August 1982, we provided the Congress an initial assessment of the 1981 legislation in our report entitled Early Observations on Block Grant Implementation (GAO/GGD-82-79, Aug. 24, 1982).

Subsequently, we embarked on a program designed to provide the Congress with a series of comprehensive, updated reports on states' implementation of these programs. The first of these reports, entitled States Are Making Good Progress in Implementing the Small Cities Community Development Block Grant Programs, was issued on September 8, 1983 (GAO/RCED-83-186). This report addresses the implementation of the maternal and child health (MCH) services block grant.

HISTORY OF THE MATERNAL AND CHILD HEALTH PROGRAMS

The federal government has helped fund state health services to mothers and children under title V of the Social Security Act since the mid-1930's. Concerned over maternal death rates, in 1935 the Congress enacted title V of the Social Security Act--Maternal and Child Health and Crippled Children's Services--to provide health services to mothers and children, particularly in rural areas suffering from severe economic distress. Under the program, allotments were made to states, which then (1) determined how funds would be spent and (2) were required to match a certain portion of the federal allotment with their own funds. Few major changes were made to the title V program over the next 25 to 30 years, except for increased authorization levels.

In the 1960's, however, the Congress created two special project grant programs under title V in addition to the existing formula grant programs. In 1963, under the Maternity and Infant Care program, project grants to state and local health departments were authorized to help reduce mental retardation and infant mortality primarily by providing prenatal, postnatal, and postpartum care, and family planning services. In 1965, under the Children and Youth program, the Congress authorized project grants to states for comprehensive health care services for preschool and school-aged children--particularly those from low-income families. The projects provided screening, diagnosis, prevention services, treatment, correction of defects, and aftercare for children.

In 1967, the Congress made major changes in the title V program. It required that between fiscal years 1969 and 1972 specific portions of the title V appropriation be used for the following activities:

--50 percent would be allotted to states for maternal and child health and crippled children's formula grants, of which 6 percent would be used for family planning services;

--40 percent would be awarded to public and private nonprofit entities for the two special project grants authorized in 1963 and 1965, as well as special projects for dental health of children, intensive infant care, and family planning; and

--10 percent would be available for maternal and child health research and training.

In 1973, the Congress delayed the effective date until 1975 of the change in the federal policy for funding of maternal and child health special project grants by distributing funds for these projects to the states through formula grants. As a result of the change, 90 percent of the title V appropriation was allotted to states for maternal and child health and crippled children's services. States then determined what services to fund, provided their programs included at least one special project in each of the following areas: maternity and infant care, children and youth, family planning, dental health, and intensive infant care--commonly referred to as the "program of projects." Between 1975 and 1981, no substantive amendments were made to title V except for increases in authorizations.

THE MCH BLOCK GRANT

Subtitle D of title XXI of the Omnibus Budget Reconciliation Act of 1981 amended title V of the Social Security Act to establish the MCH block grant. This block grant became effective October 1, 1981, and states had until October 1, 1982, to accept administrative responsibility. By August 1982, every state and territory was administering the MCH block grant.

The purpose of the MCH block grant is to enable each state to assure mothers and children access to quality health services, reduce infant mortality and incidences of preventable diseases and handicapping conditions among children, provide rehabilitation services for blind and disabled children under the age of 16, and provide various services for crippled children. The block grant consolidated the following prior categorical grant programs: maternal and child health services, crippled children's services, supplemental security income services for disabled children, hemophilia treatment centers, sudden infant death syndrome, lead-based paint poisoning prevention, genetic disease testing and counseling, and adolescent pregnancy prevention.

The 1981 act requires states to provide the Secretary, Department of Health and Human Services (HHS), information on MCH block grant activities, including (1) a report describing the intended use of payments, including a description of areas within the state needing maternal and child health services, a statement of goals and objectives for meeting those needs, information on the types of services and categories of individuals to be served, and data the state intends to collect on program activities, (2) a statement which, among other things, assures that the state will provide a fair method for allocating funds under the 1981 act to areas in need and will use funds allotted to the state to carry out the purposes as required by the act or to continue activities previously conducted under the consolidated MCH health programs, (3) an annual report on block grant activities, and (4) at least biennial audit reports of program expenditures.

The 1981 act authorized $373 million to be appropriated for fiscal year 1982 and for each fiscal year thereafter for the MCH block grant. The Secretary of HHS was to retain 15 percent of amounts appropriated in fiscal year 1982 and not less than 10 nor more than 15 percent in subsequent years for special projects of regional and national significance and for research and training related to health services for mothers and children as well as genetic disease and hemophilia programs. The remainder of the appropriation is distributed among states on the basis of the state's proportion of total funds allotted to all states in

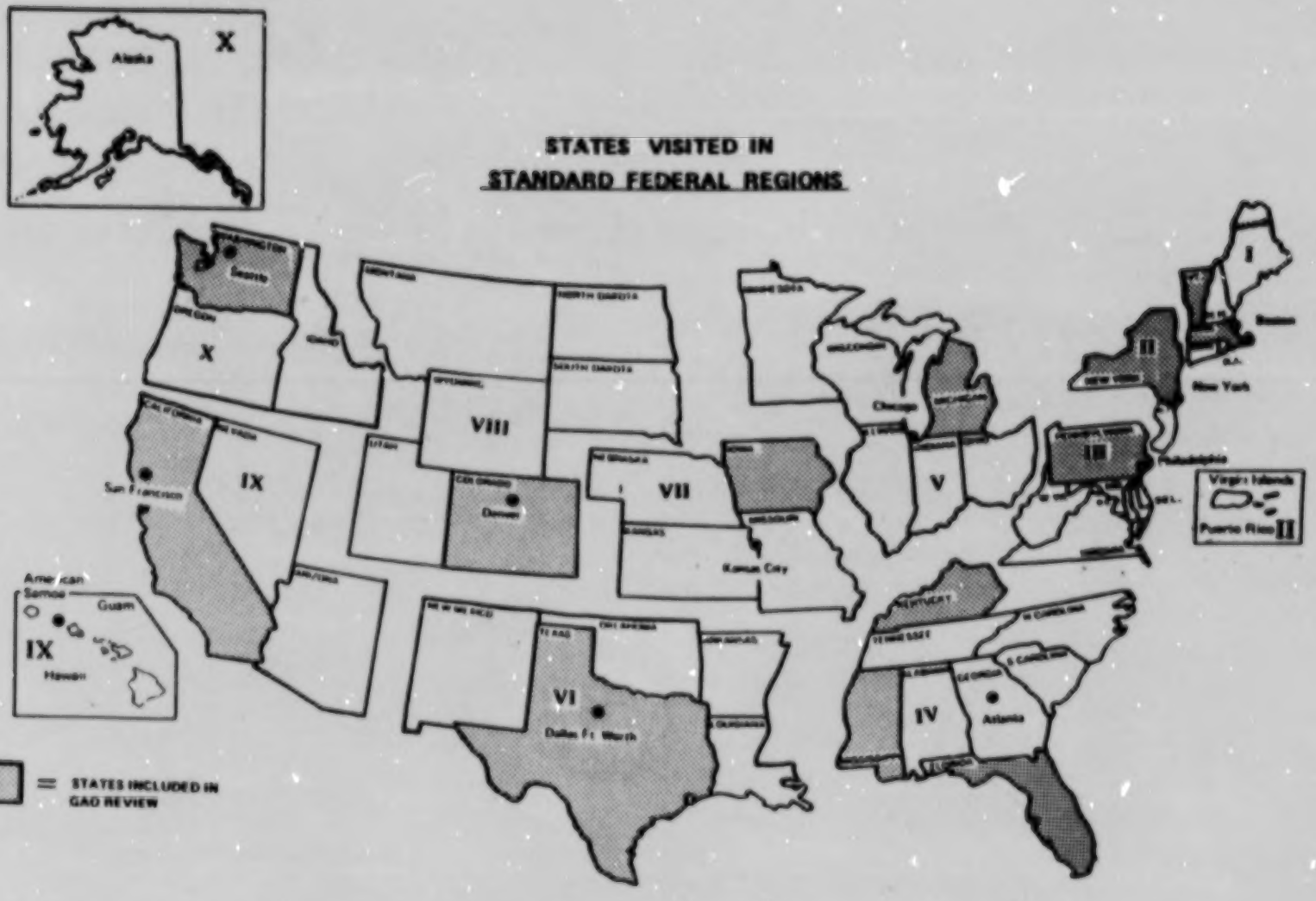
fiscal year 1981 under certain categorical programs included in the block. Also, states must spend 3 state dollars for every 4 federal block grant dollars spent.

In fiscal year 1982, $372 million was appropriated for the MCH block grant programs compared to $455 million in fiscal year 1981. This represents about an 18-percent reduction over the last categorical grant year. In fiscal year 1983, $373 million was appropriated for the MCH block grant programs. During fiscal year 1983, however, the Emergency Job Appropriations Act of 1983 (Public Law 98-8), commonly referred to as the jobs bill, was enacted. As a result of this legislation, an additional $105 million was appropriated for the purpose of increasing availability of essential health services for disadvantaged mothers and children. Officials in the 13 states told us that most of these moneys would be spent in 1984 because they were received late in states' fiscal year 1983.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our primary objective in work on all block grants is to provide the Congress with comprehensive reports on the states' progress in implementing them. To do that, as shown in the map on the following page, we did our work in 13 states: California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont, and Washington. These states were selected to attain geographic balance. The states had (1) differing fiscal conditions and varying ranges of per capita incomes, (2) varying degrees of involvement by state executive and legislative branches in overseeing and appropriating federal funds, and (3) a variety of service providers offering services to mothers and children. At least one state was selected in every standard federal region and, in total, the 13 states accounted for approximately 45 percent of all block grant funds and an equivalent portion of the nation's population. In addition, these states accounted for about 40 percent of MCH block grant funds. Our sample of 13 states was a judgmental selection and not intended for projection purposes.

Our review focused on how states are implementing the MCH block grant and what changes, particularly those related to the block grant, have occurred since the consolidation of the prior categorical programs. Information was obtained at three management levels: HHS headquarters, the state, and service providers.


STATES VISITED IN
STANDARD FEDERAL REGIONS
X
Alaska
X
VIII
IX
San Francisco
Denver
VII
Kansas City
VI
Dallas Ft Worth
V
II
New York
III
Philadelphia
I
Virgin Islands
Puerto Rico
II
IV
Atlanta
American Samoa
Guam
IX
Hawaii
= STATES INCLUDED IN GAO REVIEW

At the federal level, we obtained MCH fund allocations for fiscal years 1981, 1982, and 1983 and certain program information from HHS headquarters in Washington, D.C. Also, we discussed with headquarters officials HHS policies for implementing and monitoring the program.

At the state and local levels we used a wide variety of data collection instruments and approaches to obtain information from individuals or organizations responsible for or having an interest in (1) a single block grant and (2) multiple block grants. These instruments were designed with the objective of gathering consistent information across states and across block grants where reasonable and practical.

The first set of information sources included state program officials responsible for administering the MCH block grant and individual service providers. To obtain information from these sources, we used a state program officials questionnaire, financial information schedules, a state audit guide, a service provider data collection guide, and an administrative cost guide.

Almost identical versions of the program officials questionnaire and administrative cost guide were used for all block grants. The other three instruments had to be tailored to each block grant because of differences in the types of programs and services provided under each block grant and the manner in which financial information had to be collected.

The service provider data collection guide was used not to obtain comprehensive data from the service provider level but rather to identify examples of the implications, for service providers, of state policies and practices in block grant implementation. We visited 44 service providers which were judgmentally selected by taking into consideration types and size of service providers, location in the state (urban and rural areas), and types of MCH services provided. In our selection, we attempted to include, where appropriate, at least three service providers from each state we visited and at least three service providers for each of the prior categorical programs consolidated into the MCH block grant. The number of service providers visited represents a small portion of the total number of service providers in the 13 states.

The second set of information sources included representatives from the governor's office, various officials from the state legislature, and public interest groups. To obtain information from these sources, we used questionnaires which generally asked about the respondent's specific experience with the block grants and obtained perceptions concerning the block grant concept.

The questionnaire sent to public interest groups solicited their views concerning how the state in which the group is located had implemented and administered the block grant. We identified interest groups through several sources, such as contacting about 200 national level organizations, mailing lists provided by HHS and a private organization with extensive knowledge about block grants, and officials in the states we visited. Although not a representative sample of all concerned public interest groups, we mailed out 1,662 questionnaires pertaining to all block grants under review and received 786 responses, of which 249 indicated having at least some knowledge of their state's implementation of the MCH block grant. These 249 respondents became the basis for our analysis of public interest groups for the MCH block grant; however, not all 249 responded to each question.

A detailed discussion of the content, source of information, and method of administration for each data collection instrument is included in appendix I. Our work was done in accordance with generally accepted government auditing standards.

All questionnaires were pretested and subjected to external review prior to their use. The extent of pretest and review varied, but in each case one or more knowledgeable state officials or other organizations provided their comments concerning the questionnaire or completed it and discussed their observations with us. Also, the service provider data collection guide was discussed with various service providers. The design of the financial information schedules was developed in consultation with the Association of State and Territorial Health Officials, the Urban Institute, and HHS. The photographs included in this report were provided by Children's Hospital National Medical Center, Washington, D.C.

Our fieldwork on the MCH block grant was carried out primarily between January and August 1983. At the conclusion of our work, individual state summaries were prepared containing the data developed using the financial information schedules and the state audit guide. We briefed state officials on the information contained in the summary and gave them an opportunity to comment on its accuracy and completeness. Particular attention was given to the financial information, and state officials were asked to review the data to ensure that the data accurately represented trends in the use of categorical and block grant funds over the 1981-83 period. Our summaries were modified, where appropriate, on the basis of comments provided by state officials. The final summaries, together with information received directly from questionnaire respondents, were used to prepare this report.

In addition, HHS officials provided oral comments which were limited to a few points of clarification and were considered in preparing this report. HHS officials stated the report will be useful to the agency during their efforts to monitor the program.

The information presented in this report was developed for the purpose of assessing the status of MCH block grant implementation and not intended to evaluate states' effectiveness in devising or managing programs. The following chapters focus on the funding patterns that have emerged under the MCH block grant and how they differed from the prior categorical programs; the changes that have been made at the state and service provider levels to the types of MCH services offered and how they are delivered; state organization and management changes that have been made; and the involvement of citizens, state elected officials, and interest groups in processes which led to decisions on how block grant funds would be used.

CHAPTER 2

STATES ASSUME MORE OF THE FUNDING BURDEN AND BEGIN TO MODIFY PROGRAM PRIORITIES

A major objective of block grants was to provide states more authority to determine their needs and establish funding priorities. States historically have had key roles in administering certain federal maternal and child health activities, but the block grant expanded opportunities to alter the funding patterns established under the prior categorical programs. Such opportunities, however, were tempered by the reduced federal funding levels associated with the block grant.

Despite smaller federal allocations, total MCH expenditures increased from 1981 to 1983 in most states we visited. The increases were attributable to increased state and other contributions and the continued availability of funds from the prior categorical programs. Although the amount of available categorical funds decreased by 1983, the emergency jobs bill legislation provided substantial additional federal support in late 1983 and should allow relatively stable funding in 1984.

While funding levels have been a central concern, states have used their expanded flexibility in reassessing program priorities and have integrated planning for block grant funds into their overall health planning and budgeting process. Essentially, states have placed great importance on maintaining continuity with the funding patterns established under the prior categorical programs and, accordingly, have made few substantial departures from those patterns. However, states have tended to provide more support for broader program areas which had received the bulk of state funds under prior categorical programs and relatively less support for certain smaller, more narrowly targeted activities which were previously mandated or directly funded by the federal government.

STATES INTEGRATE MCH BLOCK GRANT PLANNING INTO OVERALL STATE HEALTH PLANNING AND BUDGETING PROCESSES

Planning for the MCH block grant program is integrated into states' overall health planning and budgeting processes. Rather than operating as a separate activity, the block grant constitutes a funding source to help support MCH-related state health programs. In this way, decisions on how to use MCH block grant funds are linked to broader decisions on state health programs and are made in the context of the overall availability of funds from federal, state, and other sources.

Although federal MCH block grant funds account for a small percentage of a state's overall health budget, they do finance a significant portion of state programs focusing on maternal and child health. In each state we visited, MCH block grant funds comprised less than 9 percent of its total 1983 health budget. However, in 8 of the 13 states, block grant and ongoing categorical outlays represented at least 30 percent of total 1983 expenditures for maternal and child health program areas, and in no state did they represent less than 14 percent.

The bulk of the remaining program support in most states comes from state revenues. Additionally, states supplement state and block grant moneys by using funds from other federal sources, such as title XIX, Social Security Act, Medicaid funds for children and title XX, Public Health Service Act, Adolescent Family Life program. Some states also obtain funds from other sources, such as local cash matching requirements or fee schedules.

Although block grant planning is integrated with states' overall health planning and budgeting processes, the extent of integration varies. In some states, the processes are closely intertwined, and MCH block grant plans are ultimately prepared directly from the budget. In Florida, for example, MCH block grant priorities are established through the same process used in the overall health planning and budgeting cycle, and the state MCH block grant plan is essentially based on the final budget passed by the legislature. Likewise, in Michigan, relevant data from the state's health budget are used to prepare the MCH intended use report required to be submitted to HHS.

In other states, MCH block grant planning is separate and feeds directly into the budget. For example, in New York, the health department has a separate budget process for federal funds and state funds. For federal funds, a report is submitted to the state legislature reflecting the health department's plans and budget for the MCH block grant. Subsequently, budget proposals for federal funds are integrated with those for state funds as part of the state's overall budget request to the legislature.

TOTAL EXPENDITURES INCREASE IN MOST STATES

From 1981 to 1983 total MCH expenditures increased in 8 of the 11 states that had operated the MCH block grant during this 2-year period.[1] As shown in table 2.1, total expenditure increases in these eight states ranged from 4 percent in Massachusetts to 42 percent in Vermont. Also, during this period, in Colorado, Iowa, and Pennsylvania total expenditures decreased by 11, 6, and 7 percent, respectively.

Table 2.1

Changes in States' Total MCH Program Expenditures[a] Since Implementing the MCH Block Grant 1981 - 1983

State	Expenditures 1981	1982	1983	Change (1981-83) Dollars	Percent
	(millions)				
Colorado	$ 14.9	$ 15.0	$ 13.3	$(1.6)	(11)
Florida	53.8	59.7	63.6	9.8	18
Iowa	7.6	7.3	7.1	(0.5)	(6)
Kentucky	21.8	23.4	24.5	2.7	12
Massachusetts	17.1	16.9	17.7	0.6	4
Michigan	34.0	33.5	35.9	1.9	6
Mississippi	13.1	14.6	16.6	3.5	27
Pennsylvania	51.6	48.4	48.0	(3.6)	(7)
Texas[b]	43.7	48.0	57.5	13.8	32
Vermont	3.4	4.0	4.8	1.4	42
Washington	11.0	11.5	12.3	1.3	12
Total	$272.0	$282.3	$301.3	$29.3	11

[a]Total expenditures include federal MCH categorical and block grant funds; other federal funds for related programs; state funds; local matching funds; fees for services; and copayments and reimbursements, such as from Medicaid.

[b]Texas reported additional 1983 expenditures from other federal sources, but they were excluded from this table because comparable data were unavailable for 1981 and 1982.

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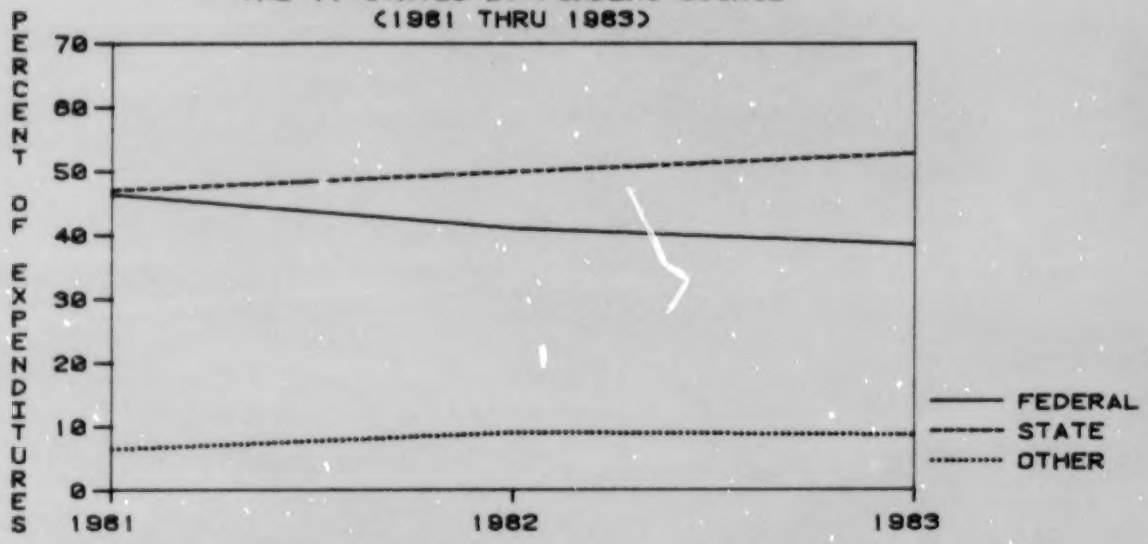
[1]We visited 13 states in total, but because California and New York did not have 2 years' experience with the MCH block grant at the time of review, they are discussed separately on pages 24 and 25.

Increased expenditure of state and other funds was a major factor enabling most states to maintain or increase total MCH expenditures between 1981 and 1983. Accordingly, as shown in chart 2.1 for the 11 states, state and other sources each began shouldering an increased proportion of total expenditures while the federal share declined. Moreover, this greater reliance on both state and other sources of funds occurred in 9 of the 11 states as detailed in appendix II.

CHART 2.1
PERCENT OF MCH EXPENDITURES FOR THE 11 STATES BY FUNDING SOURCE (1981 THRU 1983)



As shown in table 2.2, when total expenditures are adjusted for inflation, a somewhat different picture emerges. After considering the inflation factor for state and local purchases of goods and services of about 7 percent a year over the 1981-83 period, 7 of the 11 states experienced a decrease in constant dollars ranging from 1 percent in Kentucky to 21 percent in Colorado. The remaining four states experienced an increase in constant dollars ranging from 4 percent in Florida to 24 percent in Vermont.

Table 2.2

Changes in States' Total MCH
Program Expenditures When Adjusted for Inflation
1981 - 1983

State	Expenditures			Change	
	Actual		1983	Dollars	Percent
	1981	1983	adjusted[a]	adjusted	adjusted
	(millions)				
Colorado	$ 14.9	$ 13.3	$ 11.7	$(3.2)	(21)
Florida	53.8	63.6	54.8	1.0	4
Iowa	7.6	7.1	6.2	(1.4)	(18)
Kentucky	21.8	24.5	21.5	(0.3)	(1)
Mass.	17.1	17.7	15.5	(1.6)	(9)
Michigan	34.0	35.9	31.5	(2.5)	(7)
Miss.	13.1	16.6	14.6	1.5	11
Penn.	51.6	48.0	42.1	(9.5)	(18)
Texas	43.7	57.5	50.4	6.7	15
Vermont	3.4	4.8	4.2	0.8	24
Washington	11.0	12.3	10.8	(0.2)	(2)
Total	$272.0	$301.3	$264.3	$(7.7)	(3)

[a]The 1983 figures are adjusted for inflation using an index of state and local purchases of goods and services. Using this basis, costs increased by 13.5 percent from 1981 to 1983 (7 percent increase from 1981 to 1982 and 6.5 percent from 1982 to 1983). The adjustment index for 1983 was computed on the basis of actual data for the first three quarters of 1983 and projections for the fourth quarter of 1983. Projections were provided by the Wharton Econometrics.

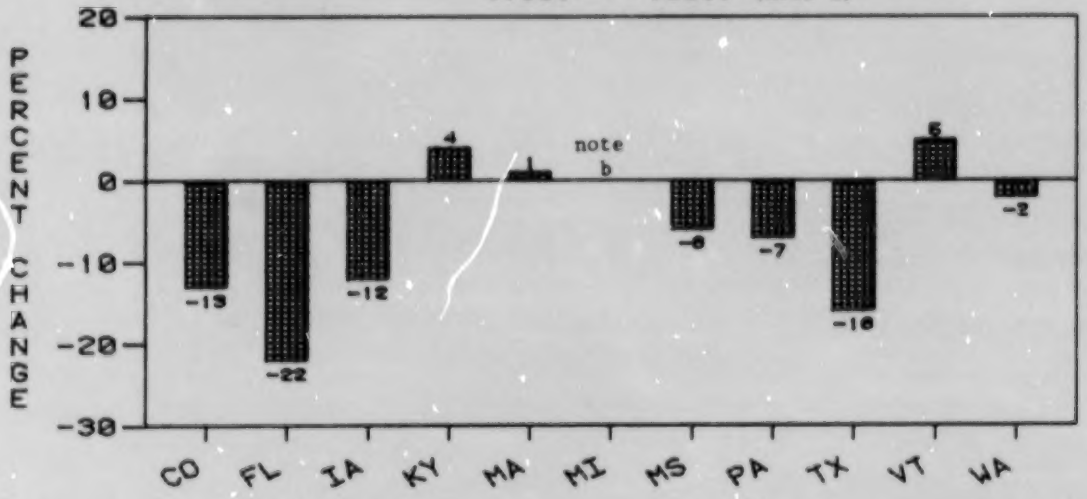
EXPENDITURE OF FEDERAL FUNDS DECREASES BUT NOT AT SAME RATE AS APPROPRIATIONS

Federal funding has been a major, and for some states the primary, source of funds for MCH programs. With the implementation of the MCH block grant, total federal appropriations were reduced by about 18 percent from 1981 to 1983.[2] These

[2]Federal MCH appropriations for fiscal year 1983 decreased 18 percent compared to 1981 funding levels, excluding the funding from the emergency jobs bill legislation. As discussed on page 19, the majority of these additional funds will not be spent until fiscal year 1984.

reductions, however, usually did not translate into equivalent declines in the expenditure of federal categorical and block grant funds as shown in chart 2.2. Only in Florida did expenditure of federal categorical and block grant funds decrease at a greater rate than the 18-percent reduction in total federal MCH block grant appropriations.

CHART 2.2
PERCENT CHANGE IN THE EXPENDITURE OF FEDERAL CATEGORICAL AND BLOCK GRANT FUNDS FOR MCH PROGRAMS BY STATE (1981 -- 1983) (note a)



[a]Appendix III shows changes by state in expenditure of federal funds from 1981 to 1983.

[b]Less than 1 percent increase.

A major reason most states did not experience expenditure reductions similar to the federal funding reduction was the availability of substantial federal categorical funds during the first year of block grant implementation. These ongoing categorical outlays helped offset the impact of reduced block grant appropriations and allowed states to carry forward 1982 block grant funds into 1983. To a lesser extent the availability of other federal funds, such as transfers from other block grants, also helped lessen the adjustment to reduced federal funding in a few states.

Ongoing categorical funds mitigate impact of federal funding reductions

Most of the categorical programs consolidated into the MCH block grant were project grants or had a project grant component funded for at least a 12-month period. These grants were awarded to state and local entities at various times throughout fiscal year 1981, many in the last quarter. Fifty-seven percent of the 1981 categorical grant awards for the states we visited extended into 1982.

As a result, even though states had block grant funding available, many state and local organizations were able to provide services well into fiscal year 1982 with 1981 categorical funds. As shown in table 2.3, all 11 states reported expenditure of categorical funds in 1982 with such funds comprising at least 32 percent of combined categorical and block grant funds expended in 9 of the 11 states. The expenditure of categorical funds decreased to almost $4.6 million in 1983 from the approximate $33.5 million expended in 1982.

Table 2.3

Expenditure of Categorical Funds During Block Grant Years

State	Categorical funds expended 1982 (000 omitted)	Percent of combined categorical & block grant expenditures	Categorical funds expended 1983 (000 omitted)	Percent of combined categorical & block grant expenditures
Colorado	$ 2,924	41	$ 194	3
Florida	3,563	32	75	1
Iowa	2,322	44	25	a
Kentucky	3,838	52	401	6
Massachusetts	3,409	34	1,333	13
Michigan	2,067	17	536	4
Mississippi	3,822	57	394	6
Pennsylvania	7,270	37	1,095	6
Texas	587	4	194	1
Vermont	541	47	53	5
Washington	3,128	41	293	4
Total	$33,472	32	$4,593	4

[a]Less than 1 percent.

The continued expenditure of categorical funds, coupled with the 2-year availability of block grant allocations, allowed states more time to plan for the use of block grant funds and gave them the flexibility to maintain a reserve of funds to buffer the uncertainties of future federal allocations. According to state officials, they carried forward substantial amounts of federal fiscal year 1982 MCH block grant awards into federal fiscal year 1983, and many were projected to carry forward a large percentage of block grant funds into 1984. For example, the impact of federal funding cuts was cushioned in Mississippi by the ongoing expenditure of categorical funds in 1982. Furthermore, the state carried over about 23 percent of its 1982 block grant funds to 1983 and projects that it will carry over 29 percent of available funding into 1984. In Washington, ongoing outlays from categorical programs resulted in unobligated block grant funds at the end of 1982 and enabled the state to carry over 18 percent of its block grant award into 1983. In addition, Washington projects that it will carry over about 33 percent of available funds from 1983 to 1984.

Other federal funding sources supplement federal block grant allocations

In addition to MCH categorical funds and block grant allocations, other federal funds were available to support MCH programs. For instance, although states cannot transfer MCH block grant funds to support other programs, funds can be transferred into MCH from other block grants. Four of the 11 states exercised this option during 1982 or 1983, although the transferred funds represented only a relatively small source of funds.

Colorado transferred $143,000 (1982) and $178,000 (1983) from its alcohol, drug abuse, and mental health block grant to MCH programs. Vermont supplemented MCH funding by transferring $61,000 (1982) and $74,000 (1983) from its social services block grant, while Iowa supplemented its program by transferring $70,000 (1983) from its preventive health and health services block grant. In Mississippi, $700,000 (1983) was transferred from the Low-Income Home Energy Assistance block grant and was used to fund several projects including two maternity programs in high-risk areas in the state.

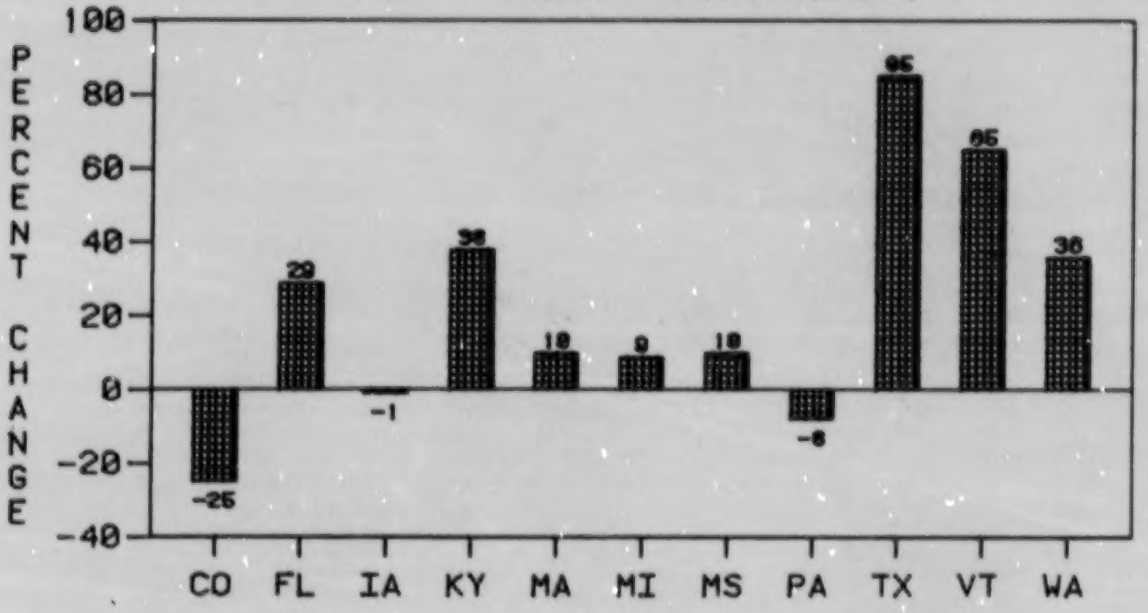
Although 10 of the 11 states expended funds from other federal sources, these funds generally represented a small percentage of total MCH expenditures. Such sources included title XIX, Social Security Act, Medicaid funds for children and the new title XX, Public Health Service Act, Adolescent Family Life program. In 9 of the 10 states reporting other federal funds, these funds accounted for approximately 10 percent or less of

total expenditures in 1983, while in Vermont they equaled 13.5 percent. For the nine states having consistent data for the 1981-83 period, five experienced increases from these other federal funding sources. For example, in Vermont title XIX expenditures for Medicaid-eligible children increased from $54,000 to $93,000 for dental programs which are related to MCH programs.

INCREASING EXPENDITURE OF STATE AND OTHER FUNDS REDUCES IMPACT OF FEDERAL REDUCTIONS

For the 11 states, expenditure of MCH-related state funds increased from a total of about $128 million in 1981 to about $159 million in 1983, or 24 percent. As shown in chart 2.3, expenditure of state funds increased in 8 of the 11 states ranging from 9 percent in Michigan to 85 percent in Texas. In the three remaining states--Colorado, Iowa, and Pennsylvania--state expenditures decreased by 25, 1, and 8 percent, respectively.

CHART 2.3
PERCENT CHANGE IN THE EXPENDITURE OF STATE FUNDS FOR MCH BLOCK GRANT PROGRAMS (1981 - 1983) (note a)



[a]Appendix IV shows changes by state in expenditure of state funds from 1981 to 1983.

Increased expenditure of state funds was the primary factor contributing to seven of the eight states experiencing overall funding increases for their MCH programs. Conversely, the 3 states with decreased expenditure of state funds were the only states among the 11 that experienced overall expenditure declines for their MCH programs.

One factor influencing increases in expenditure of state funds, in addition to the apparent high priority states place on health care for mothers and children, was the anticipated reduction in federal funding. For example, Vermont increased its expenditures by 65 percent to offset anticipated reductions in federal funding, thereby eliminating the need to close some Department of Health district offices. Similarly in Michigan, the state increased the expenditure of state funds by $1.3 million when federal funding declined.

Another factor possibly contributing to increased expenditure of state funds was the change in the matching requirement. Under two of the eight categorical programs, states had to match on a dollar-for-dollar basis a specified portion of their federal funds. Although states historically provided more matching funds than were mandated, the categorical matching provisions generally resulted in states being required to match less than half of total federal funds in 1981.

Although the MCH block grant lowered the dollar requirement for matching from a dollar-for-dollar basis to $3 state funds for $4 MCH block grant funds, it increased the base of funds to be matched since all federal block grant funds have to be considered as opposed to only a portion of categorical funds. As a result, states generally have to provide more matching funds. This requirement could have a greater impact on states where federal funds are the primary source of funds for MCH programs, such as Iowa. However, since it was not practical to isolate what portion of the prior categorical funds expended were subject to the matching requirement, we did not determine what portion of the increase in state expenditures was attributable to the change.

Although state funding was the primary reason for increases in total MCH expenditures, expenditures from local and other sources also were a factor in some states. Funding from local and other sources represented only 9 percent of total MCH expenditures in 1983 in the seven states which were able to report consistent data on expenditures from local and other sources between 1981 and 1983. As shown in appendix V, in five of these states, such expenditures increased by $8.8 million, with the largest percentage increases occurring in Iowa (196 percent) and Mississippi (126 percent).

This rise in expenditures from local and other sources was attributable to increased fees for services or matching funds and a greater emphasis on obtaining reimbursements from third parties. For example, expenditures from other sources in Mississippi increased from about $2 million in 1981 to about $5 million in 1983 as the state implemented a sliding fee scale and began concerted efforts to obtain reimbursement from Medicaid to maintain services. In Iowa, such expenditures represented a small funding source but rose from $113,000 in 1981 to $334,000 in 1983 partly because the state established a sliding fee scale in anticipation of reduced federal funding.

JOBS BILL INTRODUCES A NEW SOURCE OF FEDERAL FUNDS

In March 1983, the Congress passed the Emergency Jobs Appropriations Act of 1983 (Public Law 98-8). This law, commonly known as the jobs bill, provided funds for job opportunities and health services, of which $105 million went to the MCH block grant. The 11 states received about $29 million, or 27 percent. This increased these states' original 1983 federal allocations by about 33 percent. These funds were received late in the states' fiscal year 1983 and, according to state officials, will be spent mainly in fiscal year 1984.

Reportedly, most of these funds will be used for maternal and child health and crippled children's services with emphasis on economically disadvantaged individuals. For example, Michigan plans to distribute a small portion of the jobs bill funds on a per capita basis while most will be allocated to geographic areas using a formula weighted for high-risk infant births, mortality rates, and unemployment rates. When Massachusetts allocated jobs bill funds, it considered both the previously identified needs of disadvantaged mothers and children and newly identified needs arising from the recession. An underlying concern in deciding how to use jobs bill funds was expressed by program officials in Texas, who wanted to avoid starting new programs that would have to be cut back or eliminated once this one-time funding source was depleted.

EXPENDITURE TRENDS REFLECT STATES' MCH PROGRAM PRIORITIES

With few exceptions, categorical program areas funded in the 11 states in 1981 continued to receive support in 1983. While states have attempted to maintain continuity with the funding patterns established under the prior categorical programs, they have generally provided more support for program areas where they had previously committed most of their funds

and less support for the smaller, more narrowly targeted program areas that had been mandated or directly funded by the federal government.

The crippled children's and maternal and child health services areas together continued to account for 92 percent of total MCH program expenditures, but table 2.4 shows that changes in expenditures by MCH program area varied considerably. Crippled children's services, which historically has been the heaviest state-funded program area, increased by $24 million, or 23 percent, whereas the maternal and child health program area increase was negligible. Overall expenditures for genetic disease testing and counseling, adolescent pregnancy prevention, and hemophilia program areas increased between 1981 and 1983. Although most states supported one or more of these program areas with block grant or state funds in 1983, direct federal support continued to be a key element in determining expenditure trends. However, lead-based paint poisoning prevention and sudden infant death syndrome (SIDS) program area expenditures decreased when state support did not increase enough to compensate for diminished direct federal support. Expenditures for services to disabled children receiving supplemental security income (SSI) benefits decreased in several states as their services and related expenditures were accounted for in conjunction with the crippled children's services program area. Expenditure changes by program area for each state are shown in appendixes VI through XIII.

Table 2.4

Changes in Expenditures by Program Area

Program	1981 Expenditures	1983 Expenditures	Change	
			Dollar	Percent
	----------(thousands)--------			
Crippled children	$105,962	$130,169	$24,207	23
Maternal and child health	146,056	146,811	755	1
Genetics	3,801	4,356	555	15
Adolescent pregnancy	2,236	2,584	348	16
Hemophilia	2,553	2,624	71	3
SIDS	785	690	(95)	(12)
Lead-based paint	3,895	3,159	(736)	(19)
SSI	4,772	4,299	(473)	(10)

As total expenditures for program areas changed, programs' proportions to total expenditures also changed, as shown in appendix XIV. In the 11 states, for example, the crippled children's program area accounted for 39 percent of 1981 total expenditures, whereas with funding increases, it constituted 43 percent of the 1983 total expenditures. In contrast, the maternal and child health program area as a proportion of total expenditures decreased from 54 to 49 percent over the 1981-83 period. This expenditure pattern was true for these two program areas for most of the states we visited. For 7 of the 11 states, expenditures for the crippled children's area as a proportion of total expenditures had increased. At the same time, the percentage devoted to maternal and child health services in six of those seven states had declined. On the other hand, the percentage of total expenditures directed to the other smaller program areas combined was mixed among the 11 states with such proportional expenditures increasing in 6 states and declining in 5 states.

The following sections highlight funding trends for each program area. The programmatic implications of changes in funding for each program area are discussed in chapters 3 and 4.

Crippled children's services expenditures increase in most states

In 8 of the 11 states, total expenditures increased for their crippled children's services. As shown in appendix VI, these increases ranged from 1 percent in Pennsylvania to 50 percent in Vermont. In only three states--Colorado, Iowa, and Mississippi--did expenditures decrease for this program area by 12, 8, and 5 percent, respectively.

By far the largest increases in expenditures occurred in Texas and Florida, accounting for over 80 percent of the net increase for all 11 states. According to a state official, Texas increased its crippled children's program by $10.9 million to help compensate for inflation and to expand direct care services to children. In Florida, the increase in crippled children's expenditures of $9.1 million was mainly due to increased costs for purchasing client services from health professionals and related hospitalization fees.

In four of the seven states that consolidated or were in the process of consolidating the SSI program for disabled children into their crippled children's program, expenditures for crippled children's services increased. Although these states could not always readily identify how much of their 1983 expenditures related to the former SSI program, this consolidation would account for only a small portion of the crippled

children's increases, because the 1981 SSI expenditures in these seven states totaled only about $1.9 million.

Maternal and child health research, training, and services--mixed expenditure trends among states

In 5 of the 11 states, expenditures increased for their maternal and child health research, training, and services program area, while in 6 states such expenditures decreased. As shown in appendix VII, the increases ranged from 6 percent in Texas to 49 percent in Vermont. The states with decreases ranged from less than 1 percent in Michigan to 15 percent in Pennsylvania.

Mississippi experienced the largest dollar increase, while Pennsylvania by far experienced the greatest decline. Mississippi's $3.6 million increase in program expenditures resulted from folding some prior categorical programs into the general maternal and child health program area, initiating a statewide sliding fee scale, and transferring funds into the MCH block grant from the Low-Income Home Energy Assistance block grant. According to a Pennsylvania state official, that state's decrease of $5.5 million was due partly to a decline in school enrollments with a corresponding reduction in expenditures for school health programs and a reduction in administrative costs associated with the program. Some of the reduction also was attributable to reduced expenditures under the program of projects for mothers and children that was no longer required by the MCH block grant.

Funding for such special projects in the 11 states, which accounted for almost one-fourth of their total expenditures for MCH research, training, and services in 1981, was reduced by 21 percent from 1981 to 1983 in part because several states provide similar services under broader state programs. Reduced support for these projects occurred in almost every state and helped account for the limited overall growth in the maternal and child health research, training, and services program area expenditures.

Lead-based paint poisoning prevention and SIDS expenditures decline

Under the prior lead-based paint poisoning prevention and SIDS categorical programs, funds were frequently provided directly to local entities, bypassing state health authorities. Since beginning block grant administration, most states in which these programs are operated have chosen to use block grant or state funds to support them. Expenditures for lead-based paint poisoning prevention and SIDS projects, however, generally

declined between 1981 and 1983 as direct federal support diminished and states often cited the need to fund higher priority areas.

This trend was most evident for lead-based paint poisoning prevention. Of the 11 states, 6 reported expenditures in 1981. As shown in appendix VIII, expenditures in 1983 for five of these six states had decreased from 1981 levels, ranging from 18 percent in Michigan to 100 percent in Texas. Only Pennsylvania had increased expenditures, by 17 percent.

To a lesser extent, SIDS expenditures followed a similar pattern (see app. IX). Of the 10 states where we could obtain comparable 1981 to 1983 data, 6 had decreased expenditures, ranging from 5 percent in Iowa to 100 percent in Texas. Four states, however, experienced increases--from 15 percent in Vermont to 86 percent in Pennsylvania, with Mississippi just beginning its program in 1982.

Continued direct federal support remains a key factor in expenditures for other smaller program areas

Expenditures for adolescent pregnancy prevention services, genetic disease testing and counseling services, and hemophilia diagnostic and treatment centers in the 11 states increased overall between 1981 and 1983, although changes in expenditures varied by state (see apps. X through XII). However, aggregate expenditures which could be separately identified for these program areas constituted less than 3 percent of total MCH expenditures in the 11 states. While most states expended block grant and state funds for one or more of these program areas in 1983, in the vast majority of cases, prior categorical awards and/or the HHS Secretary's set-aside fund were also key factors in determining trends in expenditures among the states.

This was particularly true for genetics and hemophilia services, which are specifically mentioned in MCH block grant legislation as being eligible for the Secretary's set-aside funding. As shown in table 2.5, in 5 of the 6 states where hemophilia is funded as a separate program area and in 6 of the 11 states where genetic services are funded, prior categorical awards and/or the Secretary's set-aside funds constituted at least 60 percent of their total 1983 expenditures. Additionally, such funds accounted for at least 20 percent of total expenditures in four more states for genetics.

Table 2.5

Percentage of Total 1983 Expenditures Derived From Federal Categorical and/or Set-Aside Funds

Percent of total expenditures	Number of states		
	Hemophilia	Genetics	Adolescent pregnancy
100	4	3	1
80-99	0	2	1
60-79	1	1	0
40-59	0	0	0
20-39	0	4	2
0-19	1	1	4
Total number of states where separate activities were funded	6	11	8

The exception to this general trend for hemophilia services was in Pennsylvania, which operated a program largely with state funds. Iowa was the exception in genetics; it operated a genetic disease counseling program essentially from its own funds.

In contrast to the general trend in hemophilia and genetics, less than 20 percent of total expenditures for adolescent pregnancy prevention services were derived from categorical or Secretary's set-aside funds in four of the eight states in which separate activities were operated. In two states, such funds accounted for at least 80 percent of total 1983 expenditures, and in Vermont and Colorado they were at least one-fourth.

SIMILAR EXPENDITURE TRENDS EMERGE IN CALIFORNIA AND NEW YORK

At the time of our review, California and New York were only completing their first year of experience with the MCH block grant, which they accepted in July 1982, whereas the other 11 states began to administer the program in October 1981. In many respects, first-year changes in expenditures for California and New York paralleled trends in the other 11 states. For example, total expenditures increased in both California and New York. California's total expenditures increased by $10.5 million (13 percent) from 1982 to 1983 with expenditures from each funding source increasing--federal (13 percent), state (15 percent), and other (11 percent). New York's total expenditures increased by $877,000 (1 percent) during the same period with expenditures of state and federal funds remaining relatively

constant, while expenditures from other sources increased by about 3 percent. When adjusted for the 6.5-percent inflation factor for state and local purchases of goods and services over the 1982-83 period, California still experienced an increase of 6 percent, whereas New York experienced a 5-percent decrease.

In California and New York, categorical funds were also available for expenditures during their first block grant year (1983), although to a lesser extent than in most of the other 11 states in 1982. (See table 2.3.) In 1983, expenditures of categorical funds in California totaled $347,000, or 1 percent of federal categorical and block grant expenditures, and in New York, categorical expenditures were $9.2 million, or 31 percent of expenditures from categorical and block grant funds.

Changes in expenditure patterns among the smaller program areas were similar in California and New York to patterns in the other 11 states, as shown in appendixes VIII to XII. Expenditures significantly decreased for the lead-based paint poisoning prevention and SIDS program areas. Like the 11 states, expenditure trends varied among the three remaining smaller program areas. In California expenditures increased for hemophilia services, adolescent pregnancy prevention, and genetic disease testing and counseling services. In New York, however, although comparable data on genetics was unavailable, expenditures for the two other smaller program areas declined.

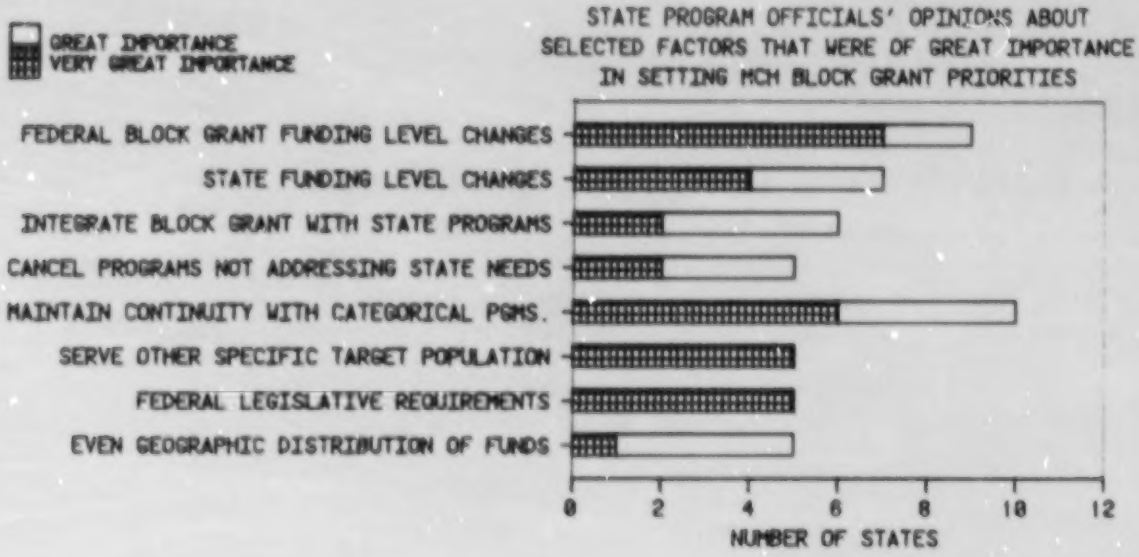
As in the other 11 states, the crippled children's and maternal and child health program areas continued to account for the bulk of total expenditures. Unlike many of the 11 states, however, the largest proportional increase in expenditures occurred for maternal and child health services in these two states. The proportion of expenditures for these services increased by 1.9 percent in California and by 4.0 percent in New York, as shown in appendix XIV.

MAINTAINING CONTINUITY AND FUNDING CHANGES ARE INFLUENTIAL IN SETTING PRIORITIES

Program officials from all 13 states considered a number of factors in establishing priorities for programs supported with MCH block grant funds. As shown in chart 2.4, the factor most often cited as being of great importance was the desire to maintain program continuity. Officials in 10 states cited this factor to be of great importance, and it was of some importance in all 13 states. Thus, states' decisions to continue funding predecessor categorical programs were influenced by their desire to maintain continuity. This emphasis may have resulted from a continued need for the services and a desire to minimize the disruption of ongoing services until states have had more experience with the block grant.

Another important factor in establishing program priorities was changes in the level of federal and state funding. At least seven of the states we visited cited one or both of these funding sources as being of great importance in establishing MCH program priorities. With the reduction in federal allocations accompanying the MCH block grant, most states increased state funding to help maintain program services.

CHART 2.4
STATE PROGRAM OFFICIALS' OPINIONS ABOUT SELECTED FACTORS THAT WERE OF GREAT IMPORTANCE IN SETTING MCH BLOCK GRANT PRIORITIES



CONCLUSIONS

Although federal allocations decreased as states began implementing the MCH block grant, total expenditures for all program areas supported with MCH block grant funds increased in most states we visited. This was primarily due to increased expenditure of state and other funds, which began to represent a larger percentage of total program costs. Moreover, the availability of prior categorical funds during block grant implementation mitigated the impact of federal reductions and enabled states to carry over block grant funds into future years. Furthermore, the substantial additional funds provided to states through the federal emergency jobs bill legislation should help promote relatively stable funding in 1984.

In using the expanded flexibility offered by the block grant to establish program priorities, states were motivated by several key factors. The desire to maintain continuity of services was the factor most frequently cited as greatly important. Accordingly, states continued supporting most of the same program areas funded under the prior categorical programs with few exceptions. Additionally, changes in the level of federal and state funding frequently influenced the priorities assigned to the various program areas.

Expenditure trends showed states emphasizing broader statewide program areas which had historically received most of the states' funds. A large proportion of expenditures went for crippled children's services and maternal and child health research, training, and services under the block grant, as it had previously. Moreover, crippled children's services, historically the most heavily state-funded area, accounted for most of the total expenditure increases. In contrast, although states usually supported certain smaller, more narrowly defined program areas under the block grant, their support was not always great enough to bring total expenditures up to the levels under the prior categorical programs. As a result, expenditures for two program areas, lead-based paint poisoning prevention and SIDS, decreased overall. However, the continued availability of direct federal funds contributed to increases in total expenditures for each of the other smaller categorical program areas.

The following two chapters explore the programmatic implications of state funding decisions in each program area. They also describe states' rationales for changes in the types of services provided under the block grant and include observations of local organizations responsible for delivering services to the public.

CHAPTER 3

TYPES OF MCH AND CRIPPLED CHILDREN'S SERVICES CONTINUE RELATIVELY UNCHANGED BUT SELECTED AREAS REFOCUSED

The MCH block grant gave states greater flexibility to determine what services would be offered and to design programs more in accordance with their perceptions of state and local needs. Because states already had considerable involvement in tailoring the types of services provided under the prior crippled children's and maternal and child health categorical programs, many adjustments in the types of services offered reflected the results of ongoing program assessments, rather than changes attributable to the block grant.

The MCH block grant did, however, provide states the opportunity to make certain program service modifications which were not previously possible. The most frequently reported changes were consolidating services for disabled children receiving SSI benefits with states' broader crippled children's programs and reducing or eliminating support for special projects required to be funded under the prior maternal and child health categorical program. States often reported making these changes because services offered were duplicative or comparable services were available under other state programs.

In addition to contacting state agencies, we visited 21 service providers responsible for delivering maternal and child health research, training, and services. These providers were very diverse in their type of organization, range of services provided, and size of operations. While these service providers were generally aware of the MCH block grant, few could attribute program changes directly to it because of a multiplicity of other factors influencing their operations. As a result, providers were in relatively unique situations, and the type and scope of program adjustments made over the 1981-83 period varied widely.

CRIPPLED CHILDREN'S SERVICES-- A CONTINUING PRIORITY

All 13 states had a long-standing program to meet the needs of children with crippling conditions. Because each state historically had great flexibility to develop its program and to decide who was eligible to receive services, there were a wide range of diagnostic, treatment, and rehabilitative services provided across the 13 states. Typically, services are provided by state health agencies and physicians on a fee-for-service basis and include screening, diagnosis, surgical and other corrective procedures, hospitalization and aftercare, and speech, hearing, vision, and psychological care.

Corrective procedures and physical therapy are instrumental in assisting a child to cope with a handicapping condition.

The crippled children's services program continues to be a high-priority program, with most states increasing its funding since adopting the MCH block grant. In addition, no state reported dropping any services provided under their crippled children's program. While a few states added services, changes most often attributed to the block grant included merging services for disabled children receiving SSI benefits into the broader crippled children's program and modifying criteria for determining who is eligible for services.

Changes in crippled children's services most often include consolidation of SSI

With few exceptions, most states reported offering the same types of crippled children's services under the block grant as provided under the predecessor categorical program. No state reported deleting services and four reported adding services, including hearing screening for high-risk infants in California, services for neurological disorders and childhood cancer in Texas, and case management services, such as family counseling, in Michigan. Michigan's experience with its crippled children's program disclosed a need for introducing home care counseling to teach a family to cope with a handicapped child's unique needs and adapt such items as toys and clothing.

In addition, Washington added selected vision and eye services out of a desire to serve expanded target populations and to take advantage of improvements in medical technology. State officials also said they placed greater emphasis on early intervention due to greater capability in this area and a desire to serve other geographic areas. Because of limitations on funding and a desire to serve other target populations, however, the state gave less emphasis to medical, surgical, and corrective services, and speech and hearing services. Finally, Pennsylvania has reduced emphasis on diagnosis, hospitalization, and aftercare services; for example, it now limits funding for patients with cystic fibrosis to 5 days of hospital care, rather than unlimited hospitalization.

The most frequently reported change directly attributable to the block grant was the consolidation of the SSI program for disabled children into states' crippled children's programs. In 1976, the Congress established a separate categorical program to assist disabled children receiving SSI benefits. Under this program, the Social Security Administration referred blind and disabled children under age 16 receiving SSI benefits to designated crippled children's services state agencies for counseling and other services. For these children, the state agencies established individual service plans and provided referrals for services. In addition, they provided medical, social, developmental, and rehabilitative services mainly to children under age 7.

With the advent of the MCH block grant, 8 of the 13 states we visited decided to consolidate activities focused on assisting children receiving SSI benefits into their crippled children's programs. Officials from these states believed the consolidation permitted them to eliminate what they considered to be duplicative services and, in some cases, expand the scope of SSI services. For example, Florida stopped providing individual

care plans under its SSI program because a similar service existed under its crippled children's services program. After gaining some experience with their SSI program, Michigan state officials believed that not every family needed comprehensive assistance on a long-term basis. Because similar types of services were provided under their crippled children's program, they used the block grant flexibility to combine counseling and family support services for the two programs and to extend SSI services into previously unserved areas.

Five states did not report any consolidation of their SSI and crippled children's programs. Of these five, Kentucky, Pennsylvania, and Texas increased expenditures for their SSI programs, while Massachusetts and New York reported reduced expenditures. The largest changes occurred in Kentucky and Massachusetts.

Kentucky initiated its SSI program in 1981, and expenditures increased as the program expanded to reach its 1983 operating level of $275,000. Massachusetts attributed its decrease in expenditures of $183,000 and associated reduction in staff to declining categorical carryover funding in 1983 and decreasing program emphasis. A portion of the decline was also due to shifting overhead costs to the state's overall health budget. Although Massachusetts health officials said that types of services offered essentially have not changed since 1981, they reported placing less effort on developing and documenting individual care plans and giving greater emphasis to such areas as counseling, technical assistance, and training because the need for these services was greater.

Many states changed
beneficiary eligibility criteria

The predominant criteria states considered important in determining who is eligible for crippled children's services were need for service and age. Many states also considered family income to be important. Since implementing the MCH block grant, 8 of the 13 states changed at least one of these criteria.

The MCH block grant legislation prohibits the charging of fees for services to low-income mothers and children and requires that when fees are charged they reflect the income, resources, and family size of the beneficiary. Since the advent of the block grant, six states changed their income requirements, or implemented or revised fee schedules. For example, in anticipation of reduced funding, Iowa initiated a sliding fee scale that charged families with incomes above 150 percent of the poverty level. Those between 150 to 300 percent of the poverty level pay on a sliding fee scale and those over 300 percent pay the full amount.

Similarly, Mississippi instituted a sliding fee scale, taking into consideration income and family size. The fee schedule is based upon federal poverty guidelines and includes a "no pay" category for those qualifying as unable to pay. State officials concluded that implementing the patient fee system could result in a reduction of visits, but were monitoring the implementation to assure against adverse impact. They did not believe the impact would be significant since the average fee charged each patient was only $2.60 as of March 1983.

Three states also changed age requirements for eligible recipients. Massachusetts reduced its age requirement for crippled children's services from 21 to 18, since state officials believed most active treatment is complete at this age, whereas Washington made the same change as a cost-containment measure. At the same time, Massachusetts raised its age requirement for SSI services from age 16 to 18 to be consistent with its crippled children's program. Finally, Michigan expanded SSI service coverage to children aged 7 to 16 as a result of consolidating its SSI and crippled children's services. Although children up to age 16 were eligible for services, only those 7 and below were being served in 1981 and 1982 due to limited state resources.

MCH RESEARCH, TRAINING, AND SERVICES--SELECTED ASPECTS CHANGED

Because states for years had discretion in determining services to provide under their maternal and child health services program, they essentially continued to offer the same types of services since implementing the MCH block grant. The services typically included prenatal care, postpartum care, family planning, intensive infant care, health assessment for preschool and school age children, adolescent health assessment, immunization, nutrition education, and training of personnel. Many types of organizations are eligible to provide maternal and child health services, including state and local health agencies, hospitals, and clinics; private hospitals and clinics; and other nonprofit agencies. Colleges and universities primarily focus on maternal and child health research and training.

Although states had considerable discretion to design their maternal and child health program before the block grant, they were mandated to use a portion of their categorical funds to provide a program of five special projects. Under the block grant, however, this requirement no longer existed, and 12 of the 13 states either reduced or eliminated funding for these projects. Although states made other changes to their maternal and child health services program, these were generally attributable to ongoing assessments of program needs and not a direct result of the block grant.

To obtain a local perspective on changes made to service provider operations since state implementation of the MCH block grant, we visited 21 organizations that experienced a variety of changes to their maternal and child health research, training, or services operations.

Reductions made in program of projects

Under the prior categorical program, states were required to provide at least one special project in each of the following five areas: maternal and infant care, children and youth, family planning, dental health, and intensive infant care. This collection of projects was commonly referred to as the "program of projects." Since implementing the MCH block grant, funding for program of projects in the states we visited was reduced by almost $10 million, or 20 percent--from $48.4 million to about $38.8 million.

Routine checkups for both children and mothers are an important element of preventive health care within the maternal and child health program area.

As indicated in table 3.1, each of the five project areas was reduced, with projects for children and youth and maternal and infant care experiencing most of the reduction.

Table 3.1
Maternal and Child Health Program of Projects by Major Program

Major program	Last pre-block year	1983	Change	
			Dollars	Percent
	----------(thousands)----------			
Maternal and infant care	$22,870	$20,668	$(2,202)	(10)
Children and youth	19,653	13,825	(5,828)	(30)
Family planning	3,280	2,577	(703)	(21)
Intensive infant care	1,574	1,098	(476)	(30)
Dental health	1,034	598	(436)	(42)
Total	$48,411	$38,766	$(9,645)	(20)

The 13 states we reviewed reported that in 1981 they funded 145 separate projects. Although about 7 percent of these projects were eliminated, the predominant trend across states was to reduce funding for their program of projects. In addition to citing the decline in federal block grant allocations and the need to fund higher priority areas, state officials said program of projects were reduced because many served relatively narrow geographic areas and clients could obtain similar services through alternative programs. Often states chose to maintain or expand the level of basic services provided through their general maternal and child health program, rather than continue the more comprehensive services in limited geographic areas.

Examples of specific state actions in the maternal and infant care and children and youth portions of their program of projects follow.

--California reduced its children and youth projects by almost $1.4 million (60 percent). These projects are being phased out because higher priority has been given to the state's perinatal program and necessary child health services could be provided through another state program financed in part with Medicaid funds. Consequently, support services for these projects were

integrated with the maternal and infant care project, which met the state's perinatal care needs and had received increased funding of over $300,000.

--Iowa stopped funding its maternal and infant care and children and youth projects which served only a small segment of the population and were more comprehensive than other state maternal and child health services. According to a state health department official, the two organizations which ran the former projects continue to provide some maternal and child health services, and clients who previously received the more comprehensive services, such as intensive infant care, may now go to the University of Iowa hospital. The $918,000 saved by eliminating these projects was used to add two new service providers in previously unserved areas.

--Colorado decided to continue its program of projects through 1983, though at reduced levels of about 10 percent. State officials were in the process, however, of evaluating their children and youth and mothers and infants projects, and indications were that the comprehensive treatment provided by these projects may be an expensive way to deliver health care. One estimate was that it may cost twice what some of the state's maternal and child health services cost.

--New York decreased its program of projects by $1.7 million (14 percent) primarily by phasing out one children and youth project as part of a cost-cutting effort. State officials acknowledged that, although there was still a need for these services and this project's non-Medicaid population was one of the poorest in the state, the project had the highest cost per user. Officials believed adequate services were still available since the project's target area was within another children and youth target area and pediatric ambulatory care was provided by a nearby hospital.

While the largest dollar changes occurred in the maternal and infant care and children and youth projects, many states also reported reduced funding for the smaller family planning, intensive infant care, and dental health projects. Where projects were eliminated, state officials often noted that similar services were offered through their general maternal and child health programs or other funding sources, such as title X Family Planning and established state-run dental programs.

Two states increased their program of projects in the amount of dollars spent or number of projects provided.

Michigan increased funding by $118,000 (2 percent) for its program of projects. In Massachusetts, although total funding for all projects decreased by $129,000 (4 percent), the state added eight projects because of needs identified in other areas.

Changes in program services and beneficiary eligibility

Aside from service changes relating to the program of projects, many of the other service changes that states reported were not directly tied to the block grant but were attributed to continuing reassessments of recipients' needs. Most recent service changes reflected increased emphasis on services relating to improved pregnancy outcome, such as prenatal and postpartum care, nutrition, patient education, and adolescent health assessment.

For example, Colorado officials said greater emphasis was placed on two services--prenatal care, because state health officials and a women's and child health advisory council rated this to be a high priority, and adolescent services, because of a state assessment of needs and priorities and an adolescent task force review which showed that mortality and morbidity rates in youth were rising. In response, the state added seven projects and expanded others which were designed to increase service provider capability in providing prenatal and adolescent services and achieve a better geographic distribution of services. On the other hand, Colorado decreased emphasis on personnel training due to a change in priorities, but officials noted that a training project previously funded by the state had obtained alternative financing.

Although several states modified the types of maternal and child health services offered, only four reported any major changes in their beneficiary eligibility criteria. Colorado increased its emphasis on servicing low-income persons, while Iowa implemented a sliding fee scale. Two states--Michigan and Pennsylvania--said they expanded the geographic coverage of their maternal and child health programs. Of these four states, all but one attributed these changes directly to the block grant's legislative goals of targeting low-income persons and providing the state flexibility to shift funding.

Varying degrees of change reported by service providers

In addition to contacting state agencies, we visited 21 service providers in 11 states who deliver services to clients through the maternal and child health research, training, and services program. These service providers included

various types and sizes of agencies offering a wide spectrum of services. Eight were private, nonprofit organizations, primarily community and university hospitals; 13 agencies were public, government-sponsored agencies, mostly city, county, or district health departments. We visited such diverse projects as a women's health care training project with 1983 expenditures of about $200,000 and affiliated with a major university school of medicine with a $60 million budget and a general maternal and child health program that had 1983 expenditures of $2.7 million provided by a county health department with a $20 million budget.

Generally, these service providers operate in a very complex environment with a multitude of factors affecting their programs. For example, each service provider received funding from a variety of sources, including federal, state, and local governments; private grants and payments; and fees for services. Although each of the 21 service providers was generally aware of the MCH block grant, few attributed any changes directly to it.

One-third of the service providers reported decreases in total funding levels, and almost half reported decreases in numbers of clients served between 1981 and 1983. In addition, more than half reported decreased staffing levels. Trends in service delivery were mixed. Almost half reported stable service levels or mixed experience, two reported expanded service levels, and nine reported decreased service levels. In those latter cases, providers generally attempted to maintain the same types of direct medical care services offered, while reducing indirect services, such as travel and transportation, social services, and public education.

The following examples illustrate the varying scope of services provided by the organizations we contacted as well as the numerous factors influencing their operations. They also highlight the different circumstances of the providers and range of changes made to their operations.

Little change for Kentucky district health department

We visited a family planning program offered by a Kentucky district health department serving a four-county area. The department provided a variety of other services, such as well-child program, immunization, prenatal clinic, cancer screening, tuberculosis program, and nutrition and health education. Its total budget has remained at about $3 million from 1981 to 1983, although it has become more dependent on state and private revenues. Of its 1983 total budget, about 12 percent was devoted to the family planning program, which included about $70,000 of state-provided MCH block grant funds.

Service provider officials reported no significant changes in funding or types of services provided over the past 3 years. In a cost-containment effort, officials reported reducing the frequency of recurring visits for low-risk patients requiring only contraceptive aids with no adverse impact on patient care. The number of clients served increased from about 5,500 in 1982 to 7,700 in 1983. Agency officials attributed this increase to more persons utilizing services in view of the area's poor economic condition. Although the staffing level decreased from 20 to 15 since 1981, there was no reported impact on patient care since the reductions were in the administrative and clerical area.

Iowa nonprofit agency scales back services

We also visited a private, nonprofit social welfare agency which formerly administered a maternal and infant care project as part of Iowa's program of projects. Under the former project, the service provider offered comprehensive care to pregnant women and infants up to 12 months of age. Although this project was dropped, the agency still provides an adolescent group home and shelter, prenatal services, and counseling services. This service provider experienced a 20-percent reduction in total funding from $847,000 in 1981 to $681,000 in 1983. According to the project director, this occurred because the state wished to redistribute funding more evenly across the state and because of an overall decline in federal funds.

Because of reduced funding, the agency now provides less care, having eliminated four satellite offices, delivery and inpatient services, home visits, health education services, dental services, transportation services, and a toll-free telephone information line. However, preventive health services were expanded and are now provided to children up to age 5. The number of patients served has decreased from 1,795 in 1981 to 936 in 1983 primarily because the four satellite offices were closed. The staffing level has also been reduced as the comprehensive care project was refocused. Although there are no longer clinics in outlying areas, the project director believes that the agency still serves the needs of the target county. Because the service provider does not keep track of clients no longer served, there was no indication whether they had located alternative sources of services.

Mississippi reduces support for rural midwife program

We visited a rural county hospital in Mississippi which sponsors a midwife program as a special maternal and infant care project within the state's former program of projects. This

midwife program was first provided in 1969 through a local state health department facility. In 1976, the state discontinued its program and began to contract with this county hospital to provide prenatal services to low- and medium-risk women and infants residing in the target county, utilizing certified nurse-midwives as the primary care giver with doctors available on a 24-hour basis. During the past 12 years, this midwife program has delivered about 85 percent of all infants in the county.

The project's annual direct costs are about $150,000 and in 1981 and 1982, the state reimbursed the hospital $100,000 per year. In 1983, the reimbursement decreased to $50,000. In addition, according to project officials, the state health department stopped providing free family planning supplies, almost all free laboratory services, and the services of a state nutritionist. As a result, the midwife program has curtailed its family planning services, provides nutrition education by a nurse-midwife which is not considered as effective as the state nutritionist, and contracts for independent laboratory services.

According to hospital and program officials, the hospital cannot absorb these additional costs without jeopardizing the entire hospital's financial situation. Unless state support is increased in 1984, the hospital may abandon the midwife program and provide only obstetric services on an emergency basis. Program officials stated that patients now served by the program would then have to use private physicians, travel to a university medical center 80 miles away, or revert to home deliveries.

Service level not yet affected by reduced funding in Texas city health department

We visited a city health department in Texas which sponsors a maternal and infant care project. Services offered were typical of general maternal and child health programs--prenatal and postpartum care, family planning, nutrition and patient education, in-service training for nurses, immunization for children, adolescent health assessment, and dental services. The 1983 health department budget was about $35 million, of which about 5 percent was for the maternal and infant care program. This program's 1983 budget of almost $1.8 million has decreased 13 percent since 1981 because of reduced federal support. Program officials said that the MCH block grant funds received through the state accounted for about $960,000 of their funding in both 1982 and 1983, down from the 1981 federal categorical funding level of $1.3 million.

To date, however, project officials indicated that the funding reduction has had little adverse impact on program services or staffing levels because the city guaranteed support in

covering shortfalls and project officials have attempted to better use existing staff and adopt cost-cutting measures, such as restricting travel, printing, and equipment expenses. In fact, the program has increased the number of prenatal clinics because of a rising demand for services due to a growing population. Because project officials do not expect the same level of support from the city in 1984 as in prior years, they anticipated reducing staffing and patient services.

Increased funding but reduced service level in Colorado district health department

In Colorado, we visited a district health department which serves a three-county area by providing comprehensive health care to about 4,000 low-income children and prenatal care to about 850 low-income pregnant women. This health department offers special projects for children and youth, maternal and infant care, and dental services. The health department's 1983 budget was $5.3 million (an 8 percent increase over 1981), with about 25 percent of total funding spent for the three special projects.

Although total funding increased, it was not sufficient to compensate for inflation, according to a health department official. As a result, the health department reduced the scope of its services by consolidating two clinic sites into one, lowered the eligibility age for children, stopped providing free drugs and transportation services for patients, and eliminated four social worker positions. In addition, the health department may implement a sliding fee scale for patients as an alternative source of funds. A health department official believed that inflationary cost increases were more responsible for changes made in staffing and clients served than state implementation of the block grant.

Increased emphasis on preventive care in Pennsylvania university project

In Pennsylvania, we contacted an intensive infant care project which is offered within the general program of a university school of medicine. Located in an urban Philadelphia area having the highest incidence of infant mortality in the state, the service provider offers education and treatment to low-income, high-risk pregnant women; pediatric care to high-risk infants; and various social services. Reported expenditures for the intensive infant care project declined from $164,000 to $155,000 between 1981 and 1983. Although the project was supported primarily by state-provided MCH block grant funds, 14 percent of total expenditures was obtained from private local foundations and other federal sources.

The project administrator saw no real difference under the block grant because the project's funding has continued to come through the state, and the university school was sufficiently large to absorb additional costs. The only major change in services over the past 3 years has been greater emphasis on prenatal care and patient education to improve pregnancy outcome. This change was attributed to the state's increased emphasis on preventive care. In addition, the number of clients increased from 216 to 533 between 1981 and 1983, which was primarily attributed to more social and family health worker home visits with pregnant women, due to the increased emphasis on preventive care. Staffing levels have remained fairly constant.

ANTICIPATED CHANGES IN SERVICES

Six of the 13 states anticipated changes in crippled children's, SSI, and maternal and child health services programs in 1984. For example, four states plan to change or expand selected aspects of their crippled children's or SSI services. Michigan will continue to combine counseling and family support services for the crippled children's and SSI programs and, pending negotiations with local health departments, expect to offer these services statewide by October 1984. Pennsylvania will continue geographic expansion of services to children receiving SSI benefits. In addition, Iowa intends to initiate a statewide multiagency data collection system to identify and monitor handicapped children, their needs, the delivery of services, and patient outcomes. Finally, Vermont will actively seek third-party reimbursement and initiate a sliding fee scale to generate more revenue for its crippled children's services program; it will also change emphasis from service delivery for SSI clients to case management by referring beneficiaries to other service providers and providing followup services.

Four states anticipated changes in maternal and child health services. Michigan officials plan to spend block grant and jobs bill funds to expand infant health services from 9 to all 48 local health departments by October 1984 to help combat the state's high infant mortality rate. Washington anticipates more emphasis on its prenatal program in 1984, and Pennsylvania will extend its improved pregnancy outcome program into rural parts of the state. Prenatal care and adolescent services in Colorado will continue to be emphasized because they are a high priority of the health department and the MCH Women's and Child Health Advisory Council. In addition, Colorado program officials said they may make some changes to the program of projects once their evaluation has been finalized.

CONCLUSIONS

Because states have had considerable long-standing involvement in funding and designing their crippled children's and maternal and child health services programs, block grant implementation presented no radical departure from the types of services delivered. With few exceptions, states continued to offer essentially the same types of services as they did under the categorical program. As part of continuing reassessments of recipients' needs, however, several states placed greater emphasis on certain services, especially those which could improve pregnancy outcome.

Although many program service changes could not be directly linked to the block grant, certain actions taken by states to refocus selected aspects of their programs were directly attributable to their new flexibility. The most frequent changes involved merging activities directed at assisting disabled children receiving SSI benefits with the broader crippled children's program and reducing or eliminating program funds targeted for a program of special projects that was mandated under the predecessor maternal and child health categorical program. Because states often believed certain dimensions of these activities were duplicative or too narrowly focused, they often gave a higher priority to supporting general statewide programs, rather than continuing to maintain more comprehensive projects in limited geographic areas.

While states were refocusing certain program components, the 21 service providers we visited experienced a variety of changes to their operations. Some providers reported stable or increasing total funding levels and numbers of clients served, while total funding for others was on the decline and services provided and clients served had decreased. Only in a few instances could service providers attribute such changes directly to block grant implementation. Mirroring the complexity of their environment and the highly individualized situation of each organization, a diverse array of factors influenced the service providers' operations, including escalating program costs, changes in both sources and levels of funding, prevailing economic conditions which have brought about increasing utilization of services, and continuing reassessment of alternative ways to organize and deliver services.

CHAPTER 4

CHANGES IN SMALLER PROGRAM AREAS VARY

Unlike the former categorical crippled children's and maternal and child health programs, states previously had more limited involvement or control over the smaller categorical programs merged into the block grant which altogether represented less than 8 percent of total MCH expenditures. As a result, under the MCH block grant they were presented with new opportunities to exercise flexibility and establish program priorities, particularly for the program areas relating to lead-based paint poisoning prevention, SIDS, and adolescent pregnancy prevention. In the remaining two program areas--hemophilia and genetic disease--direct federal grants from the HHS Secretary's set-aside fund has remained a major factor, although some states are also using their funds to support these activities.

Changes made under the block grant varied greatly by program area and by state. Some states reduced or eliminated funding for projects previously initiated by the federal government, and others realigned the types of services offered. Conversely, some states increasingly emphasized certain programs and maintained or expanded their involvement. Similarly, experiences of individual service providers we visited were mixed and ranged from reductions in services in some to expansion of program operations in others.

ADOLESCENT PREGNANCY PREVENTION SERVICES-- MIXED EMPHASIS AMONG STATES

In 1978 the adolescent pregnancy prevention program was established to offer such services as pregnancy testing, family planning, venereal disease screening and treatment, pediatric care, adoption services, and counseling. Some service providers offer additional services, such as child care, and although many types of organizations are eligible to provide services, hospitals and clinics predominate, followed by other government and private, nonprofit entities and academic institutions.

In addition to receiving funds from states' block grant allocations, some programs offering adolescent pregnancy prevention services derive substantial support from other federal sources, such as the title XX Adolescent Family Life program and the Secretary's set-aside fund. This program area, however, is relatively small; in 1983 expenditures for specific programs offering adolescent pregnancy prevention services in the states we visited accounted for less than 1 percent of total MCH expenditures. Expenditure trends were mixed among the 10 states where

complete data could be obtained for adolescent pregnancy prevention programs, with expenditures increasing in 5 states and declining in 5 others, as shown in appendix X.

Increased expenditures were generally attributed to an increased emphasis on adolescent health services and/or a desire to continue funding former direct grantees. State officials from all five states with funding increases said they continued funding the same types of services previously offered under the categorical programs. For example, between 1981 and 1983, expenditures in Washington increased by $145,000 (91 percent) as the state continued a family counseling program and began developing a new 3-year demonstration project to consolidate services for pregnant adolescents. In 1984 four county health agencies will provide case management services and refer pregnant adolescents to other agencies providing services.

California program officials recognize adolescent health as a high-priority program, and expenditures increased for adolescent pregnancy by $66,000 (9 percent) between 1982 and 1983. Moreover, the state continued to fund three prior directly federally funded projects which offered comprehensive care for pregnant teens, such as medical and psychological care, education, and child care services. Although Colorado reported no expenditures in 1981 for adolescent pregnancy, program expenditures increased from $170,000 in 1982 to $460,000 in 1983. Because of other higher state priorities, however, the state plans to deemphasize the program in 1984.

Four of the five states with decreased expenditures since implementing the block grant attributed this trend to the loss of direct categorical grants. For example, expenditures for adolescent pregnancy prevention services decreased $114,000 (36 percent) in Michigan between 1981 and 1983. A state official said these services are being scaled back because federal set-aside funding will terminate. The state has placed a higher priority on other health programs and, in the face of the state's current depressed economy, it will not have sufficient funds to offset the loss of these direct federal funds. Although Texas continued to fund one project begun under the categorical programs, expenditures decreased from 1981 to 1983 by $285,000 because the state did not pick up funding for two former projects. According to a state official, however, these providers have located other sources of funds.

In Vermont program expenditures decreased by $44,000 (31 percent) between 1981 and 1983. According to program officials, the state continued funding a service provider which had previously received direct federal funding, but at a lower amount because of limited funds and because the project served

only one county. The service provider, however, was able to obtain additional direct federal funds through the title XX Adolescent Family Life program, which helped to compensate for the state's lower level of support.

We visited six service providers to obtain more detailed information on individual projects. These providers included one university-affiliated clinic and five nonprofit organizations. Beyond providing services or referrals oriented toward pregnancy prevention, these service providers also offered services, such as parenting education, consumer education, transportation, foster care for infants and teenagers, and day care.

Sources of funding for these service providers varied greatly and included federal sources, such as the MCH block grant and titles X and XX of the Public Health Service Act--Family Planning and Adolescent Family Life--and state and private sources. Of the six service providers visited, three had stable or increased total expenditure levels, and two had decreased levels, while the remaining organization was somewhat atypical, having received a one-time grant to develop a coordinating program for organizations offering adolescent pregnancy services. Although providers were generally aware of the block grant, only one specifically attributed changes to the block grant.

The nonprofit service provider in Massachusetts operates as a large umbrella agency over eight hospitals, two health care centers, and several local social services agencies. The organization's total funding resources increased from about $496,000 in 1981 to $745,000 in 1983 with about 25 percent of these funds spent for adolescent pregnancy prevention services. The funding increase was attributed to rising title X and XX funds as well as the state providing $171,000 in MCH block grant funds for the first time in 1983. According to the project director, the increased funding was used to hire three more counselors and to provide more home visits, better followup counseling, and services for young parents. Between 1981 and 1983 the number of clients served increased from 222 to 500.

In Florida we visited a service provider which serves pregnant adolescents through a university hospital clinic. The clinic's total 1983 budget was $1.3 million, a decrease of $273,000 from its 1981 level. Within the clinic the adolescent pregnancy project concentrates on delivering comprehensive maternity services and reducing repeat pregnancies among teenagers. From 1981 to 1983, funding for this project declined from about $175,000 to $147,000. As a result, the project's geographic coverage was reduced from three counties to one, and the number of clients served decreased from 471 in 1981 to 249

in 1982 (1983 client data were not available). The project director informed us that although the project's geographic coverage has been reduced, the types and quality of services remain unchanged.

LEAD-BASED PAINT POISONING PREVENTION PROGRAM RECEIVES GREATEST REDUCTION IN EMPHASIS

Lead-based paint poisoning is a condition where an individual has abnormally high levels of lead in the bloodstream. Excessive lead absorption, mainly through the ingestion of peeling lead-based paint chips, can result in neurological damage, such as mental retardation. This condition is often found in young children living in older, poorly maintained housing.

In 1971 the lead-based paint poisoning prevention program was established to eliminate the causes of lead-based paint poisoning and detect and treat incidents of such poisoning. Services typically include identifying areas of high risk, screening target populations, diagnosing and treating children at risk, providing educational programs to increase awareness of this problem, and identifying and removing sources of lead-based paint poisoning. Under this categorical program, service providers in most states were essentially directly federally funded, often bypassing state governments. Service providers often included local health departments and other local government agencies, hospitals and clinics, and other nonprofit entities, such as a regional antipoverty agency.

In seven of the eight states which had lead-based paint poisoning prevention projects funded under the categorical program, expenditure levels decreased since implementing the block grant. As shown in appendix VIII, expenditures decreased over 40 percent in five of these states, with reported expenditures

Blood screening tests for lead toxicity are administered to children aged 6 and under to identify the extent of a child's exposure to environmental lead.

for programs in two states (California and Texas) being eliminated. These decreased expenditure levels most often resulted from states assigning this program a lower priority in relation to other MCH funding needs. Texas, for example, preferred committing funds to basic MCH services, rather than to narrowly focused and localized lead-based paint poisoning prevention projects. Most of the service providers we visited also reported a reduction in lead-based paint poisoning prevention services offered. However, some of the service providers noted that other entities are providing additional services, such as child screening.

In addition, California decided to discontinue the lead-based paint poisoning prevention program as a separate program because state officials believed that it was not cost effective. Officials cited a low incidence of lead poisoning in the state--48 cases out of 7,711 children screened in 1982. However, California officials indicated that children with lead-based paint poisoning are still eligible for care under the state's crippled children's services program area. Similarly,

Iowa's decreased expenditure level of 51 percent can be attributed to the state assigning the program a low priority. In 1981, the state had two projects which were directly federally funded and nearing completion. In 1983, the state health department requested funds to study the need for additional lead-based paint poisoning prevention projects. The state legislature, however, did not approve the request and instead shifted these funds to the crippled children's services program.

Pennsylvania was the only state we visited which increased expenditures for this program area. The state continued funding most service providers funded under the prior categorical program and is currently conducting a statewide needs assessment to identify those areas most in need.

Two states reported recent service additions. New York added public education activities to its program in order to increase awareness. Massachusetts initiated a program in 1983 to identify areas of high risk within the state. State officials concluded that lead-based paint poisoning prevention projects were needed and are now being funded in Springfield and several southeastern communities which officials believe have a larger potential for impact. Massachusetts decreased funding, however, to existing grantees because officials believed that these efforts have been largely completed.

We visited four service providers in Kentucky, Massachusetts, Michigan, and Pennsylvania in order to obtain specific examples of changes in individual projects. Three service providers were local health departments and one was a nonprofit community action program. The provider in Massachusetts was a regional antipoverty agency serving 23 communities. The Pennsylvania and Michigan providers were city health departments, with the former serving a municipality of about 50,000 people and the latter serving a large metropolitan area. Finally, the Kentucky provider served both as a coordinating agency for other service providers within its jurisdiction and as a direct provider of services.

All four service providers offered direct services or referrals to screen for and identify high-risk children and areas, diagnose and treat affected children, and educate the general public. Some service providers offered additional services, such as laboratory testing, code enforcement (bringing housing up to legal standards), and abatement (removing the source of poisoning).

The Pennsylvania provider received increased funding through block grant funds and local contributions and reported that services, mode of delivery, and number of clients served

were unchanged during the 1981-83 period. The remaining three service providers experienced mixed funding patterns and generally compensated for any reductions in funding by decreasing their staffing level and reducing services. For example, the Massachusetts provider reduced its outreach staff, which performed door-to-door screening activities, from 15 to 2 positions and concentrated its efforts on code enforcement; staff now devote more time to court appearances and housing reinspections. In addition to reducing staff by about one-fourth and decreasing abatement services, the Michigan provider reduced door-to-door screenings and instead relied upon area hospitals. As a result, the provider believed that the project served fewer high-risk inner city children.

The service provider in Kentucky serves as a more detailed example of programmatic changes made because of reduced funding levels. The county health department's 1983 budget was $9.3 million, of which about 2 percent was spent for its lead-based paint poisoning prevention program. County expenditures for this program have fallen by 47 percent since 1981, from $398,000 to $212,000. Therefore, services offered to eliminate lead poisoning among children under 6 have either been dropped or reduced. For example, the service provider eliminated services directed at removing sources of lead-based paint poisoning and reduced education and screening services. In addition, the number of staff was decreased from 21 full-time equivalent positions to 8.

The number of clients receiving lead-based paint poisoning services from this service provider has also decreased. For example, the number of children screened dropped by 48 percent, from 1,083 in 1982 to 564 in 1983. In addition, the provider stated that it now has to depend upon individual property owners to eliminate sources of lead poisoning.

This service provider indicated that other local agencies may be picking up clients that it no longer serves. Screening services and medical evaluations are also available from two community health centers, a university school of medicine's children and youth project, and private physicians.

SUDDEN INFANT DEATH SYNDROME SERVICES--PROGRAM REDUCTIONS REFLECT CHANGING PRIORITIES

SIDS, often known as "crib death," is the sudden and unexpected death of an apparently healthy infant. In 1974 the SIDS program was established to provide counseling for families of SIDS victims and public education for health professionals as well as the general public. Other services offered included

autopsies, providing monitoring equipment and training, and research projects into the causes of SIDS. Services are provided by a variety of organizations, including state agencies, universities, local health departments, hospitals and clinics, and other nonprofit entities.

The SIDS program area is one of the smallest within the total MCH program, with 1983 expenditures representing about 0.2 percent of total MCH expenditures for the states we reviewed. SIDS services were provided in all 13 states at some time during our review, although expenditures were generally on the decline. As shown in appendix IX, for the 12 states that provided complete expenditure data since adopting the block grant, expenditures decreased in 8 states and increased in 4.

For children suspected to be at risk from SIDS, a monitor is used to check the infant's respiration and heart rate.

Several states reduced or discontinued expenditures for specific SIDS projects, often citing the need to fund higher priority programs. Additionally, some noted that although expenditures were down, services to SIDS families would still be available through other related programs. Some examples follow.

--Colorado reduced its program expenditures by 35 percent between 1981 and 1983 because officials do not consider SIDS a high priority and are encouraging the service provider to secure alternative funding.

--Florida reported that, due to higher priorities, it has reduced its public education efforts and discontinued counseling services for families of SIDS victims. Counseling, however, will still be available on an as-needed basis through public health nurses.

--California officials said that less emphasis is being placed on SIDS because no reliable method is currently available to screen for or prevent SIDS, counties already have a well-established system for following up and counseling families of SIDS victims, and state MCH staff is available for consultation on an as-needed basis. Therefore, the state opted to discontinue SIDS funding for separate projects and instead merged SIDS activities with its general MCH operations.

--New York eliminated funding for SIDS family counseling and research projects because of higher priorities and because services could be provided as part of its general MCH program.

--Michigan eliminated in-service training for local and community health department staffs and reduced its public information efforts due to a lack of funds.

In four states expenditures for SIDS increased with the largest percent increases in Pennsylvania and Mississippi. For example, Pennsylvania increased expenditures by $102,000, or 86 percent. Mississippi just began its program in 1982, offering family counseling and public education. Iowa also offered a new SIDS service in 1982--training parents how to use equipment to monitor children identified as having potential problems.

We visited service providers in Colorado, Michigan, and Washington. The provider in Michigan is a county health department which offers a wide array of health services, including a public health clinic, a paramedic unit, and Medicaid screening, child nutrition, sickle cell anemia, and SSI services. The health department's 1983 budget was $7 million, of which less than 0.1 percent was for its SIDS program. The county has routinely provided SIDS services for years through its public health nurses who make home visits. The county was aware that funds received from the state contained block grant funds but was not aware how much.

The Washington service provider is a nonprofit orthopedic hospital and medical center for children offering counseling, educational, and SIDS coordination services statewide. The hospital is funded almost totally through private grants and payments with a 1982 budget of almost $48 million, of which hospital officials estimated that 0.3 percent is for the SIDS program. In addition, they reported receiving MCH block grant funds of $17,000 and $60,000 in 1982 and 1983, respectively.

Neither the Michigan nor Washington service providers reported significant changes in clients served, staffing, or service levels in the past 2 years. This may be due in part to the fact that, for these providers, the SIDS program is a small part of a large and multifaceted program.

The Colorado service provider, however, serves as an example of an agency's efforts to maintain its level of services despite declining state support. State officials do not consider the SIDS program to be a high priority. According to the project director, this is because of its low incidence (about 100 cases per year) and difficulty in measuring program impact. In view of declining state support and the state's advice to seek alternative funding, the service provider is looking to become financially independent of federal and state funding.

This nonprofit organization provides information and counseling to families as well as SIDS education for medical professionals and the general public. Although its total funding increased from $57,000 in 1981 to almost $74,000 in 1983, there has been a major shift in its sources of funds. In 1981, a federal categorical grant totally funded the program; but since the grant expired, the state has replaced only $30,000, or 41 percent, of the program's 1983 expenditures with the remaining funding being obtained from private grants and payments. The program experienced an additional financial burden when the local hospital, which operated a similar counseling program, withdrew its support which had included free office space and various medical and administrative services.

The provider's professional staff level has remained essentially constant, while the caseload per staff member has increased; without autopsies that the hospital had conducted for this service provider, many cases are incorrectly classified as SIDS, according to project officials. As a cost-containment measure, the service provider is deemphasizing such indirect services as educational outreach to the community and professional training, while maintaining such direct services as family counseling. More severe effects have been avoided by expanding the use of volunteers to provide counseling services and obtaining additional revenue through private fund-raising activities.

GENETIC DISEASE TESTING AND COUNSELING--STATE ROLE IS INCREASING BUT DIRECT FEDERAL AID STILL IMPORTANT

Genetic disease testing and counseling services are provided to individuals with possible congenital diseases. In 1976 the genetic disease testing and counseling program was established to provide testing and screening of infants, counseling of couples to be married, and education to the public. Service providers were primarily state universities and nonprofit hospitals and clinics.

Under the prior categorical program, federal support was the primary funding source for genetic disease testing and counseling services in the states we visited. With the implementation of the block grant and associated reduction in categorical funds, 7 of the 12 states which provided complete data increased or started using state and/or block grant funds for these services. Direct federal grants from the Secretary's set-aside fund, however, were still an important funding source for genetics programs. In fact, 10 states reported receiving grants in 1983 from the Secretary's set-aside fund, which accounted for almost one-fourth of total 1983 expenditures for genetics programs in the states we visited.

As shown in appendix XI, expenditure levels varied widely between 1981 and 1983, with expenditures increasing in 7 of the 12 states, declining in 4, and remaining at a constant level in Vermont. For example, expenditures in Kentucky grew from zero in 1981 to $249,000 in 1983 as the state initiated a genetics program in response to encouragement from the Centers for Disease Control. Similarly, Massachusetts' expenditures increased from $93,000 in 1981 to $344,000 in 1983, due to increased federal categorical funding and state expenditures. Also, Iowa's expenditures increased as the state established a newborn screening unit with a grant from the Secretary's set-aside fund to complement its existing state-funded genetics counseling program.

In contrast, Colorado's expenditures decreased by $118,000, or 27 percent, because the state does not consider the genetics program to be a high priority. In view of funding declines, the state has reduced service and staffing levels, and officials are organizing a fee system for laboratory services which they hope will support the program in 1984. Similarly, Pennsylvania reported that, in view of lower funding levels for the program, it has deemphasized its screening and testing services while maintaining counseling services. Also, although Florida increased its genetics expenditures, the state has reduced emphasis on

educational activities because similar services are offered under its crippled children's program.

We visited service providers in Colorado, Florida, Texas, and Vermont to obtain information for a few specific genetics projects. Three service providers were hospitals or clinics with academic affiliations and one was a community-based health center specializing in sickle cell disease research. The three university-affiliated providers relied heavily on federal and state funds, which represented at least three-fourths of their revenue, whereas the research foundation relied heavily on United Way funding (54 percent in 1983), with additional revenue coming from federal grants (38 percent) and other private sources (8 percent). While three of the four providers were generally aware of the block grant, only the research foundation knew how much of its funds was specifically from federal block grant funds.

These four service providers reported generally stable programs. Three reported increased total expenditure levels, two reported constant staffing levels while one indicated an increase and one a slight decrease, and all four reported an increase in clients served or client encounters. Following are examples of two of the service providers.

The Colorado service provider was part of the state university health sciences center and provided such clinical services as diagnosis and followup efforts as well as educational services, such as presentations to groups and developing teaching materials. Funding for this program increased by $49,000, or 16 percent, from 1981 to 1982 but fell by 3 percent from 1982 to 1983. The program director stated that the level of funding was insufficient to meet increased personnel and overhead costs.

Consequently, two staff positions were eliminated and the sliding fee schedule increased. Client encounters, however, rose from 4,163 in 1981 to 4,870 in 1983. According to the program director, the quality of care remains the same for these clients despite the reduced staffing level because remaining staff work longer hours.

The Texas service provider we visited is a nonprofit sickle cell disease research foundation which serves a six-county area, providing blood testing, counseling, and educational services in the community, free of charge. Funded largely by the United Way, the organization has experienced a 4-percent decrease in funding, from $336,000 in 1981 to $323,000 in 1983. The provider experienced a reduced level of federal funds which the director attributed to the state's emphasis on supporting genetics programs sponsored by university medical centers.

To date, the service provider reported no significant changes in service levels or full-time staff positions, although it has more than doubled its use of volunteers since 1981 (from 13 to 28). Due to anticipated funding reductions in 1984, however, the foundation anticipates eliminating two staff positions that will limit education, laboratory, and counseling services. It is also considering implementing a sliding fee scale.

COMPREHENSIVE HEMOPHILIA DIAGNOSTIC AND TREATMENT CENTERS--STILL HEAVILY DIRECTLY FEDERALLY FUNDED

Hemophilia is a condition, usually congenital, whereby an affected person's blood fails to properly coagulate, resulting in abnormal and severe blood loss in the event of a wound. In 1975 hemophilia treatment centers were established to provide a variety of services and funding to hemophiliacs, their families, and service providers. Services provided included diagnosis and treatment to hemophiliacs on an outpatient basis, counseling to hemophiliacs and their families, laboratory services, and public education. Eligible service providers most often include state universities and hospitals and clinics--whether local, nonprofit, or for-profit.

Although states gained added flexibility under the block grant, programs targeted specifically for hemophilia centers were still predominately funded directly by the federal government in seven of the eight states which reported 1983 expenditures. The block grant legislation designated hemophilia services as eligible for funding from the Secretary's set-aside fund, and in 1983 these types of direct grants accounted for over half of total program expenditures for the seven states. The remaining state, Pennsylvania, was the only one in our review that used mainly its own funds for this program.

For example, expenditures for the Iowa-based hemophilia project increased by $78,000, or 41 percent, primarily because the state received a grant from the Secretary's set-aside fund to administer a four-state regional program. However, expenditures specifically for the state of Iowa decreased in 1983 as it began sharing this grant with other states and decreased the amount charged the federal government for indirect costs. In addition, four hemophilia treatment centers in California continue to be totally directly federally funded with reported expenditures increasing by $183,000 (39 percent) from 1982 to 1983.

On the other hand, Pennsylvania funded its own hemophilia program largely from state funds, supporting nine centers throughout the state. Only a small proportion of expenditures

for hemophilia came from federal sources. In 1983, this program's total expenditures were almost $1.7 million, of which $321,000 was from the Secretary's set-aside fund and prior categorical funds.

Consistent with the dominant role still played by direct federal funding, few programmatic changes were reported by state agencies. Only Iowa and Texas indicated major changes since implementing the MCH block grant. Iowa increased emphasis on training as it assumed increased responsibilities in administering the multistate programs. Texas is converting its hemophilia program from one supported by the Secretary's set-aside fund to a state-run program. Because state health officials wish to have a more comprehensive program, beginning in 1984 state funds will be provided for new diagnostic and treatment services.

We visited three hospitals which administer regional programs providing hemophilia services.

--One provider we contacted was one of four centers in California receiving funds directly from the federal government and serves parts of California and Nevada. The provider received a slight decrease in federal funding, from $185,000 in 1982 to $180,000 in 1983. According to officials, this decline was exacerbated by escalating hospital costs and greater difficulty in obtaining other funding support. The provider reported maintaining primary hemophilia services but reducing peripheral efforts, such as school and home visits and community education. In addition, the provider has transferred adult services to a nearby hospital in order to generate more funding support and has reduced its staffing level from 3 to 2.5 full-time equivalent positions.

--The Iowa provider was a state university hospital clinic offering services statewide and to selected areas in Illinois. The provider experienced a funding decline of almost $44,000, or 22 percent, from 1981 to 1983 despite increased funding in 1982 attributable to a four-state regional grant from the federal government. Support from the provider's sponsor hospital, however, has increased from 22 to 49 percent of its total operations. In addition, the effects of the funding reduction were lessened by training clients to handle more of their own treatment and increasing patient fees.

--The New York service provider was a nonprofit hospital serving three counties near a large city. This service provider is part of a state university medical center and

provides a wide range of services to about 247 hemophiliacs, including 24-hour emergency care, annual comprehensive evaluations, social services, complete dental services, physical therapy, orthopedic surgery, and comprehensive laboratory services. The provider experienced a funding decrease of $129,000 (40 percent) from 1982 to 1983. As a result, the staffing level has decreased from 7.5 to 5.6 full-time equivalent positions. In addition, physical therapy services and social services provided to clients have been reduced. Despite these changes, the provider said that it has maintained the quality of services and even slightly increased the number of clients served because other organizations assumed some salary costs and referrals are now made to other organizations for some services.

ANTICIPATED CHANGES IN SERVICES

Five states--Colorado, Michigan, Pennsylvania, Texas, and Washington--anticipate making major changes in their programs in 1984, as indicated below.

--Colorado is organizing a fee system for genetics laboratory services which is intended to support the program in 1984.

--Michigan plans to establish a statewide monitoring system for SIDS to compare the incidence of this problem within local communities to an established norm. If reports from local health departments vary significantly from the norm, state officials will follow up to determine whether a full-time SIDS program is needed (currently only 5 of Michigan's 48 local health departments have a full-time program), or whether infant deaths are being incorrectly diagnosed and further training is needed.

--Pennsylvania plans to increase emphasis on younger, at-risk women served by its adolescent pregnancy program and intends to use a competitive bidding mechanism to select service providers for its lead-based paint program.

--Texas will provide state funds in 1984 for new diagnostic and treatment services within its hemophilia program.

--Washington anticipates charging fees for laboratory services for its genetics program. Previously these services were offered for free, but due to funding reductions the state found it necessary to obtain additional revenue to continue the program.

CONCLUSIONS

In total, the smaller categorical program areas consolidated into the block grant accounted for less than 8 percent of total expenditures. It was in these programs, however, that states had increased opportunity to make changes due to their previous more limited involvement when these categorical programs were essentially directly federally funded. Each program area was different, however, in the types and dimensions of changes that emerged.

While the adolescent pregnancy prevention area received mixed emphasis among the states, support for lead-based paint poisoning prevention and SIDS projects generally was on the decline as state officials most often cited the need to fund higher priority areas. Although state participation increased somewhat in the hemophilia and genetic disease testing and counseling areas, direct federal involvement continued to be a major influence in funding trends and program direction.

The 20 service providers we visited had mixed experiences regarding changes in funding, staffing levels, and numbers of clients served. Some, particularly those providing lead-based paint poisoning prevention services, had reduced their staff and scope of services offered to compensate for dwindling funding levels. Others, however, which received less funding adjusted by appealing to other organizations and private funding sources for additional support, increasing patient fees, and concentrating more on direct care services.

CHAPTER 5

STATES ASSUME RESPONSIBILITIES FOR MANAGING MCH BLOCK GRANT PROGRAMS

A key feature of the block grant was the flexibility it provided states to organize their operations and adjust their management procedures so that services could be provided more efficiently and effectively. Because the states already controlled most funds awarded under the prior MCH categorical programs, the need for major organizational changes was limited. States generally assigned MCH block grant responsibilities to their state health agencies and made only minimal changes to the structure of the service provider network.

States carried out their block grant management activities by establishing program requirements, monitoring, providing technical assistance, collecting data, and auditing. These activities were often integrated with ongoing state efforts. The reduced federal requirements, together with the expanded management flexibility, produced indications of administrative simplification and management improvement. However, specific administrative cost savings could not be quantified.

ORGANIZATIONAL CHANGES LIMITED UNDER MCH BLOCK GRANT

States generally assigned block grant administrative responsibilities to the state health agencies that administered the prior categorical programs and, in certain instances, made organizational changes to improve efficiency. Also, only limited changes were made to the structure of the service provider network.

MCH responsibilities assigned to entities involved in prior categorical grants or related state activities

Because nearly 95 percent[1] of the federal funds awarded previously under the prior categorical programs went through state agencies in the 13 states, the states had an established organizational framework in place. In 12 of the 13 states, the state health agency has principal responsibility for MCH programs. In the remaining state, Iowa, MCH responsibilities

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[1]Excludes fiscal year 1982 funds awarded from the 15-percent Secretary's set-aside fund.

continue to be divided between the Department of Health and the University of Iowa, which primarily administers the crippled children's program.

In instances where the states did not administer the prior categorical programs, existing staff in state health agencies generally assumed the additional responsibility. For example, six states decided to continue lead-based paint poisoning prevention activities, which were previously funded by the federal government. In all of these states, administrative responsibility was vested in the state health agencies. Similarly, six states which had SIDS projects administered by directly funded grantees also continued the programs and assigned administrative responsibility to their state health agencies.

Although the need for major organizational realignments was obviated by states' prior involvement, a few did take advantage of their expanded flexibility. For example, Mississippi and Massachusetts integrated their SSI programs into their health agencies by transferring programmatic responsibility from other state departments. In Iowa, the university coordinated its crippled children's services with its cancer, hemophilia, genetics, and perinatal units under one umbrella agency. This was done to increase the university's flexibility in using MCH block grant funds.

Occasionally, states did not assume administrative responsibility for formerly directly funded projects. In certain programs, such as adolescent pregnancy prevention services and comprehensive hemophilia diagnostic and treatment centers, providers directly funded by the Secretary's set-aside fund are administered by the federal government.

Structure of service provider network minimally affected

Although the types of organizations eligible to provide services vary by program and state, program officials told us that, since accepting the block grant, no major changes have been made in eligibility. Nonprofit hospitals and clinics, state universities, and other nonprofit entities are the most common eligible organizations, although local health departments are also frequently used. A major exception is crippled children's services which are provided through physicians on a fee-for-service basis.

Although the eligible providers remained essentially the same, five states have changed or planned to alter the emphasis placed on the types of organizations actually used to provide services. For example, Iowa initiated two pilot projects using

private physicians to provide MCH services to new clients in rural areas where a clinic was not available. Iowa expects to fund additional private providers with jobs bill funds in 1984.

STATES HAVE ASSUMED GRANT MANAGEMENT RESPONSIBILITIES

With the implementation of block grants, the federal government has significantly reduced its grant management activities. States now primarily provide these activities by establishing MCH program requirements, monitoring, providing technical assistance, collecting data, and auditing. Often, these activities were already being carried out by the states due to their involvement with many of the prior program areas.

Requirements imposed on service providers

The block grant increased states' flexibility to manage program activities in accordance with state priorities and procedures. States no longer had to comply with certain federally imposed requirements, such as detailed reporting requirements, although the Congress did establish certain prohibitions and restrictions pertaining to the use of MCH funds. Prohibited activities include funding certain inpatient services;[2] making cash payments to intended recipients of health services; purchasing or improving land, or purchasing, constructing, or permanently improving a building (other than minor remodeling) or other facility; purchasing major medical equipment; satisfying any requirement for the expenditure of nonfederal funds as a condition for the receipt of federal funds; and providing funds for research or training to an organization other than a public or nonprofit private entity. The states primarily use service provider contracts or agreements and publication in state policy guidance or manuals to inform block grant fund recipients of the above federal prohibitions.

Twelve of the 13 states place additional requirements on some of their service providers. While the requirements often vary by program area, the most common requirement is to report on program activities and populations served. For example, New York is considering requiring, on a consistent basis, providers to report client information relating to age, sex, health condition, treatment and outcome, and cost per unit of service.

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[2]Other than for crippled children or high-risk pregnant women and infants and such other inpatient services as the Secretary may approve.

Other common stipulations include requiring service providers to conduct needs assessments; obtain prior state approval before undertaking certain actions, such as hiring personnel; match funds received from the state; arrange for audits at periodic intervals; and use the block grant funds to supplement and not supplant other funds.

Officials in two states said they had given or are considering giving local organizations greater flexibility in deciding how to use block grant funds. For example, in state fiscal year 1983, the Philadelphia Department of Health received a "mini-block" from the state which included funds for lead-based paint poisoning prevention and maternal and child health services. The mini-block was designed to offer the local health department more flexibility in using funds, and state officials said its use would probably be expanded in the future. Also, Washington plans to give four local health agencies greater flexibility in using funds for certain MCH services on a trial basis. State officials said the test was being conducted because local health agencies were concerned about the administrative burden of the state's contracting system and the desire to give local agencies the same flexibility the state had in using block grant funds.

Of the 44 service providers visited, 13 indicated that their operations had not really changed since the block grant, whereas 24 noted either positive or negative administrative benefits. Fourteen of the 24 service providers said there were positive benefits, such as a Florida provider that indicated reduced application and reporting requirements and simplified accounting procedures. Ten indicated there were negative effects, such as a New York provider which now has to follow additional state guidelines, create a policy manual, and make more frequent reports and voucher submissions. Seven of the service providers indicated both positive and negative effects, such as a Pennsylvania provider which found less reporting requirements but expressed concern over having to start competing for funds from the state.

Also, of the nine service providers who had previously received funds directly from the federal government, six said their states' payments of MCH funds were less prompt than those of the federal government, and three found the timeliness to be about the same. One provider reporting less prompt payments said the problem was severe enough to require temporary loans. Another said the state operated on a reimbursement basis instead of the federal government's advance system and that payments were 9 months behind.

In 2 of the 13 states, we asked local government organizations which were also service providers how the block grant

administrative requirements compared to those that applied to the categorical programs. Of the nine providers which responded, eight thought the administrative requirements were about the same, and one found administrative obligations associated with the block grant to be more burdensome in most aspects.

Monitoring responsibilities are integrated with ongoing state efforts

Generally, the block grant has had little effect on states' monitoring activities because block grant monitoring has been integrated with ongoing state efforts. All states monitor service provider compliance with federal and state requirements, but emphasize different issues and use various techniques.

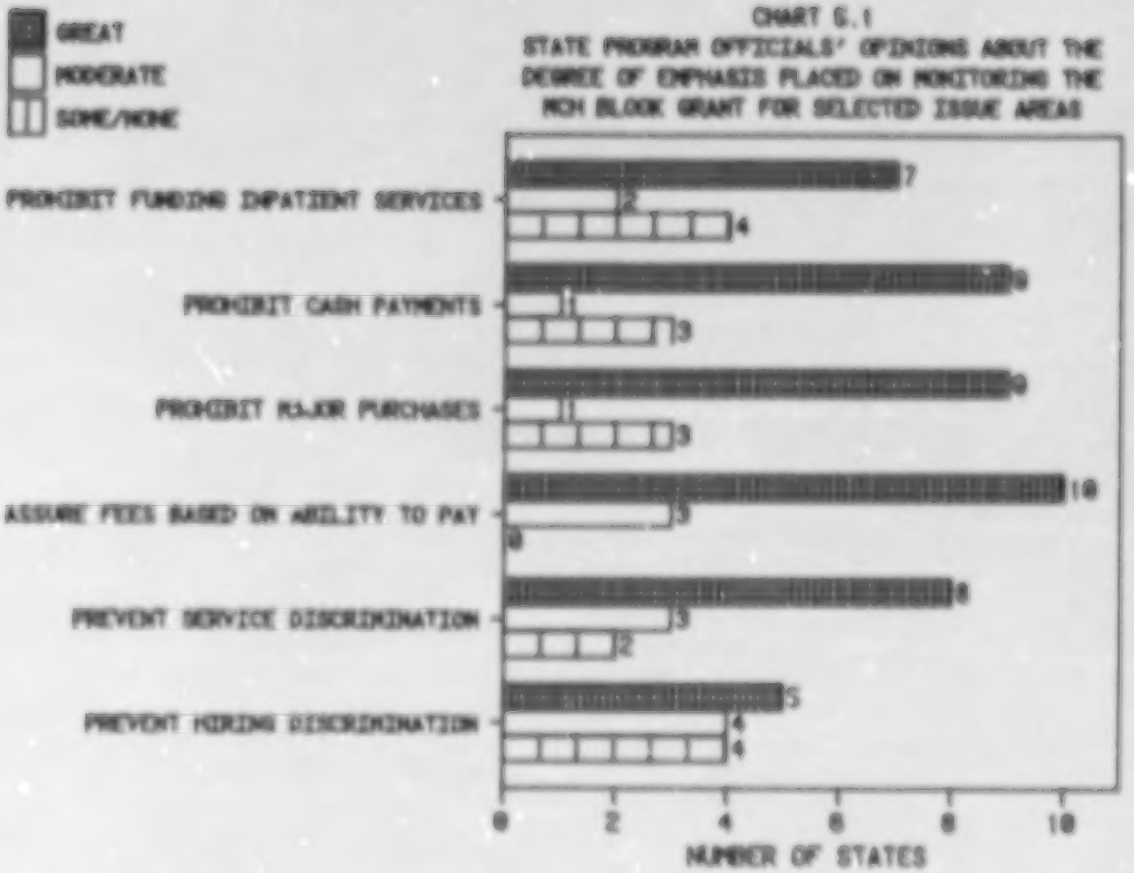
State officials reported that block grant implementation had no effect on the extent of monitoring in 9 of the 13 states. One state official said the state's monitoring efforts decreased, and three state officials said such efforts had increased. For example, an official in Iowa, where efforts decreased, explained that the state no longer operated a program of projects which had detailed federal requirements necessitating extensive monitoring efforts. Officials from Colorado explained that monitoring had increased because the state had more MCH programs.

States generally monitor service provider use of MCH block grant funds in conjunction with their use of funds from related sources. For example, Colorado officials commented that because children and youth programs received both block grant and state funding, funds from both sources are reviewed during monitoring visits.

State program officials indicated that they emphasized various issues when monitoring service providers. As shown in chart 5.1, there was considerable consistency in the degree of emphasis placed on monitoring the various federal restrictions and issues related to the use of funds. Of the items officials were asked to respond to, prevention of discrimination in hiring practices seemed to receive the least amount of monitoring emphasis.

CHART 5.1

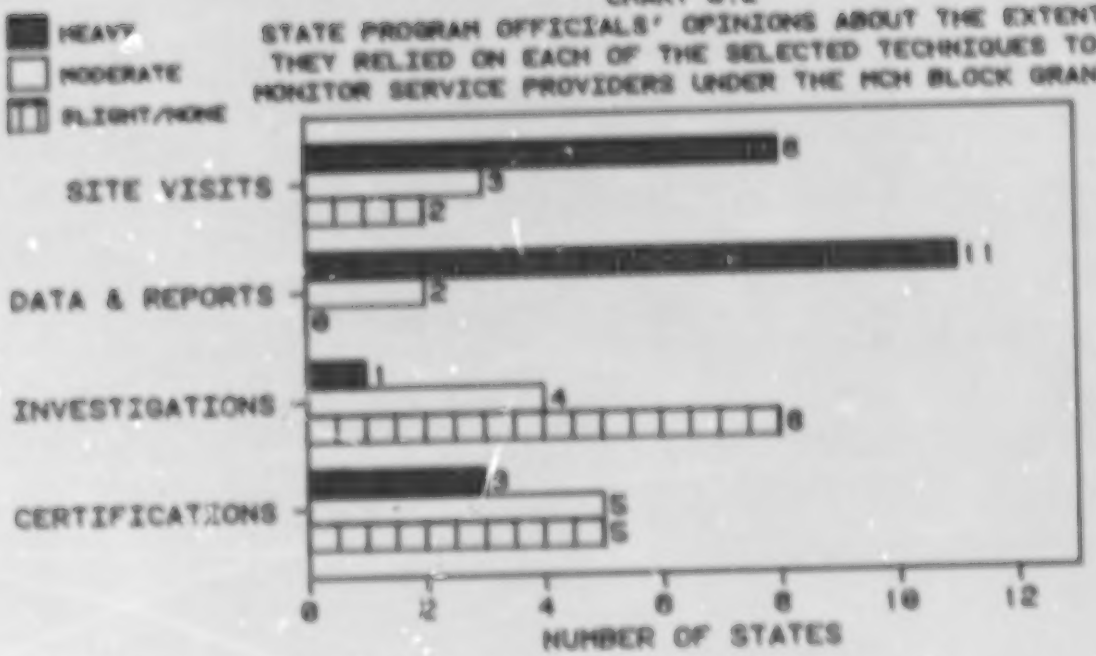
STATE PROGRAM OFFICIALS' OPINIONS ABOUT THE DEGREE OF EMPHASIS PLACED ON MONITORING THE MCH BLOCK GRANT FOR SELECTED ISSUE AREAS



As shown in chart 5.2, states relied most heavily on the review of service providers' data and reports and site visits to monitor service providers.

CHART 5.2

STATE PROGRAM OFFICIALS' OPINIONS ABOUT THE EXTENT THEY RELIED ON EACH OF THE SELECTED TECHNIQUES TO MONITOR SERVICE PROVIDERS UNDER THE MCH BLOCK GRANT



In seven states, the extent to which site visits were used varied by type of service provider or type of program. For example, Washington officials explained that the state contracts with both local health departments and other service providers for crippled children's services. Site visits are made only to local health departments, while other service providers are monitored through reviews of reimbursement vouchers.

Most states provide technical assistance

Officials in 12 of the 13 states said they provided technical assistance to local organizations providing MCH services. The recipients of technical assistance were primarily hospitals and clinics, local health departments, and universities. Voluntary organizations and local governments also received some assistance, although not as frequently. The states made the greatest use of site visits, telephone calls, letters, and state written guidance to provide assistance covering federal and state requirements, data, and other program issues.

In 2 of the 13 states, we asked service providers that were local government organizations and more likely to have some relationship with state management officials whether they had received any technical assistance or other information from the state. Of the nine service providers which responded, seven had received assistance in at least one of the areas of federal and state restrictions, applications, reporting and evaluation requirements, audit requirements, data collection, and service delivery techniques. Also, of the nine service providers, three said additional technical assistance would be helpful. For example, one state would like help in developing an accounting system compatible with local health needs.

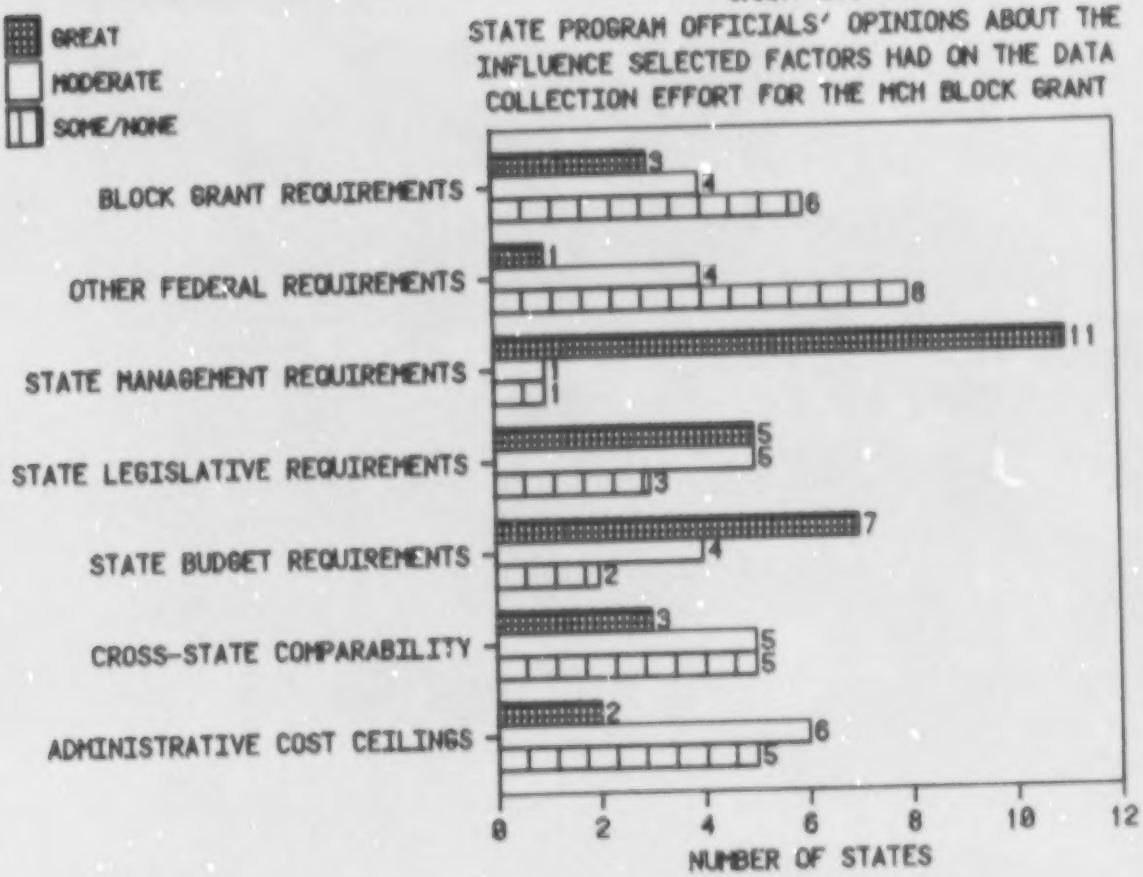
Data collection efforts remain about the same

All states collect information on programs supported with block grant funds. The most common types of data collected include quantity of services delivered, geographic location or residence of clients served, age and sex of client population served, income level of clients, quality of services, measures of program effectiveness, minority status of client population served, size of population eligible for services, and measures of service needs. The types of data least commonly collected were education level of population served and religion of client population.

Officials in 10 of the 13 states told us that the amount of funds dedicated to data collection has remained about the same since block grant implementation. While reduced federal reporting requirements would seem to suggest that such efforts would decrease, chart 5.3 shows that the state planning and management and state budget and legislative requirements are the main impetus behind state data collection efforts.

CHART 5.3

STATE PROGRAM OFFICIALS' OPINIONS ABOUT THE INFLUENCE SELECTED FACTORS HAD ON THE DATA COLLECTION EFFORT FOR THE MCH BLOCK GRANT



Officials in all 13 states reported that some additional information would be useful, but there were barriers to collecting it. The types of additional data considered most useful were those relating to measures of program effectiveness and service needs of eligible populations, the quality and quantity of services delivered, and the size of the population eligible for services. State officials said that the major barriers to increased data collection were inadequate staff and/or resources at the state level, limited financial resources, and measurement difficulties in defining and obtaining the information.

States now arrange for audits of block grant funds

State audits of MCH expenditures are a key oversight feature of the block grant legislation. States are required by law and regulations to obtain independent biennial audits of the MCH block grant and to make copies of audits available to HHS and to the public. Generally, state auditors plan to conduct state-level MCH block grant audits as part of single departmentwide or statewide audits. State officials told us that GAO's "Standards for Audit of Governmental Organizations, Programs, Activities and Functions" will be used for these audits.

Texas was the only state we visited with a completed state-level MCH audit as of October 31, 1983. According to state officials, the audit covered the Department of Health, the state agency administering the MCH block grant, and was performed in accordance with Office of Management and Budget guidance. The audit covered the state fiscal year September 1981 through August 1982. According to the audit report, the state auditor tested representative transactions, activities, and records involving federal funds, including MCH funds, and found the Department complied with the grant requirements. In addition, as of January 1984, HHS' Inspector General obtained data on 42 states showing that 17 MCH audits were complete, 16 were in process, and 9 were planned. These audits covered 1982 funds.

State agencies generally plan MCH service provider audits, but certified public accountants often conduct them. Some states plan to audit all MCH service providers, and others plan to audit providers on a sample basis. According to state officials, many MCH service provider audits will be done annually. Texas had the most comprehensive data regarding service provider audits. As of October 31, 1983, 4 MCH service provider audits were complete, 1 was in process, and 71 were planned.

BLOCK GRANT IMPLEMENTATION ACCOMPANIED BY REDUCED FEDERAL ADMINISTRATIVE REQUIREMENTS

Block grant implementation was accompanied by reduced federal administrative requirements in such areas as preparing applications and reports. In addition, it provided states with flexibility to establish procedures they believed were best suited to managing programs efficiently and effectively. Together, these block grant attributes were intended to simplify program administration and reduce costs.

Program officials in 12 of the 13 states reported that the block grant provides more flexibility than the categorical programs in allocating funds and setting program priorities. Many

states also reported that the block grant specifically enabled them to standardize or change administrative requirements and make improvements in planning and budgeting and the use of personnel. Also, although eight states reported that they were not able to reduce time and effort involved in preparing grant applications, only one state indicated spending more time and effort reporting to the federal government on block grant activities.

Block grant facilitates standardization or change of administrative requirements

Since implementation of the block grant, 9 of the 13 states said they have begun to change or standardize their administrative requirements. Officials in seven of these nine states said that the block grant was one of several major factors in their decision, and officials in four states said that the need to improve oversight of their programs contributed to the changes. The types of changes include standardizing reporting systems, standardizing certain MCH monitoring instruments, modifying service provider reporting requirements, and establishing new application procedures.

For example, Colorado officials used the increased administrative discretion provided by the MCH block grant to implement a competitive application review and awards process for nonstate service providers. Now state officials believe they will be able to evaluate competing proposals against preestablished priorities and criteria and make more informed decisions about funding service providers. Also, Washington officials are in the process of completing the procedures for standardizing the state's reporting system relating to block grant funding.

Six states plan further changes in the future. Texas officials said they will prescribe stricter procedures for disbursing, administering, and terminating block grant funds. If any agency wants to terminate or reduce a service provider's block grant funding, more extensive justification and more advance notice will be required. In New York the health department will require service providers for some programs to compete for funding through requests for proposals for projects serving high-risk populations in demonstrable need of health care. According to a state program official, this will provide an opportunity for determining better ways to provide health care, open up new geographic areas, and discourage a sense of entitlement and dependency on the part of providers.

Block grant facilitates improvements in planning and budgeting and use of personnel

Officials in 8 of the 13 states told us they were able to make specific improvements in planning and budgeting for MCH services as a result of the block grant. Some improvements include consolidating the program of projects into general health department operations resulting in increased efficiency, improving targeting of resources to high-risk groups and areas, and improving the needs assessment process.

For example, Massachusetts officials said the requirement for systematic needs assessments permitted them to change statewide distribution of funds based on need, rather than solely historical funding patterns. Also, in Mississippi, Department of Health officials told us that the elimination of the program of projects requirements permitted a consolidation of all MCH services into two program areas, maternal and child health and crippled children. They believed this eliminated duplication of some services and resulted in a more efficient method of delivering health services.

Program officials in 6 of the 13 states reported improvements in the use of state personnel. For example, Florida and Iowa officials said their staff now devotes more time to program management activities, such as planning, providing technical assistance, and monitoring, rather than fulfilling federal reporting and other compliance requirements. In Pennsylvania, officials said that the block grant resulted in clearer programmatic responsibilities and cross-program utilization of clerical staff.

Officials in 2 of the 13 states said their use of volunteer organizations had increased since accepting the block grant. In Mississippi, volunteer organizations purchased needed equipment and sponsored fund-raising activities for the crippled children's program. In Washington, the state legislature had planned to cut state funding for the dental health program and suggested that fees be charged to raise revenue. Rather than impose fees, volunteer help was solicited with good results.

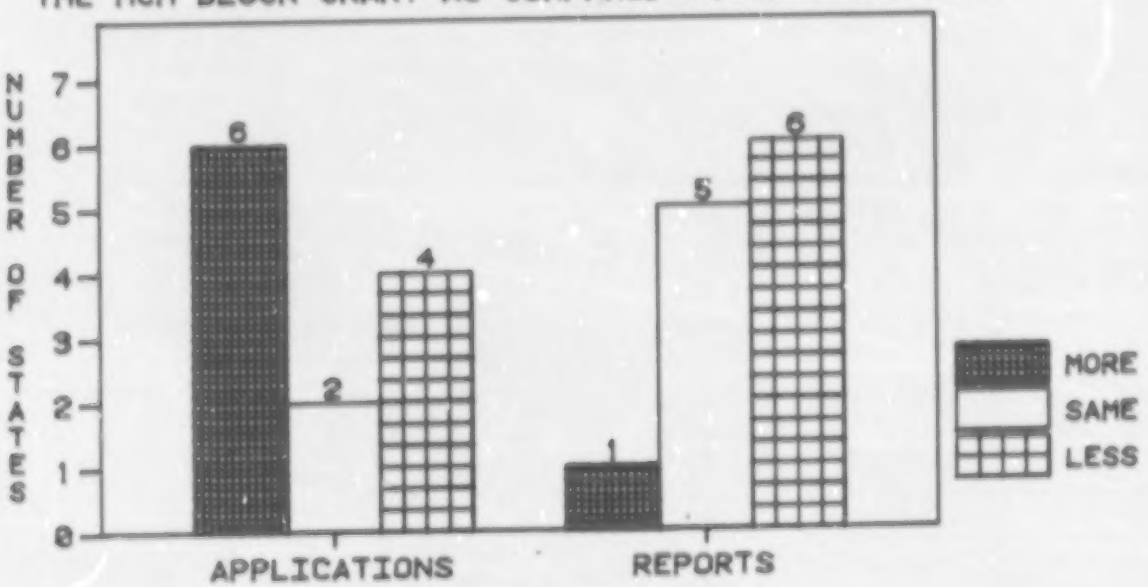
Six service providers also reported increases in their use of volunteers. For example, a SIDS service provider in Colorado hired a part-time coordinator and used approximately 50 part-time volunteers in 1982 to assist in various operational aspects of the program. In 1983, the number of volunteers increased to 130. Because of state funding reductions, officials told us this program is committed to using volunteers to continue education and counseling services.

Program officials have mixed reaction to reduced federal applications and reporting

Under the prior categorical programs, management activities, such as application preparation and reporting, had to be performed in accordance with specific federal directives. The block grant gives states greater discretion to approach these management activities in accordance with their own priorities and procedures. States must submit an application containing specified assurances and a description of how they intend to use block grant funds. Since the Secretary of HHS chose not to specify the form or content, the approach taken in preparing applications as well as the type of information included varied. Their length varied widely also.

As shown in chart 5.4, eight states were not able to reduce the time and effort spent preparing block grant applications, but only one spent more time and effort reporting on their MCH block grant activities.

CHART 5.4
STATE PROGRAM OFFICIALS' OPINIONS ABOUT THE EFFORT INVOLVED IN APPLYING FOR AND REPORTING ON THE MCH BLOCK GRANT AS COMPARED TO CATEGORICALS



Officials in 6 of the 13 states said they spent more time and effort preparing their 1983 application. Five attributed the increased effort to the need to gain public input, assess needs, and/or plan for their broader state health program. Officials in three of the six states explained that their categorical applications had become routine, with few revisions from year to year. Officials in 4 of the 13 states indicated they spent less time and effort in preparing applications, and 2 states spent about the same amount of time and effort. One state was uncertain about time and effort spent.

Officials in six states thought application requirements had a "favorable" effect on their ability to manage MCH programs. Since three of these states had also reported more time and effort spent in preparing applications, as discussed above, application requirements, such as obtaining public input, needs assessmerts, and setting program goals, were apparently viewed as beneficial. Six other states thought application requirements had no effect on their ability to manage MCH programs, and one state indicated it had a negative effect. A program official from this latter state explained that the categorical grant planning was done on a 3-year basis, whereas MCH block grant planning has to be done annually. However, the program official also indicated the annual process should result in better coordination among state agencies.

The block grant eliminated the detailed reporting requirements attached to the prior categorical programs. States must now submit an annual report to HHS on activities funded under the grant. These reports must include information to determine if funds were spent according to the law and describe who received the funds and the purpose for which funds were spent, including the progress made toward achieving those purposes. Copies of the reports must be made available, upon request, to any interested public agency and be available for public inspection within the state.

Officials in 6 of the 13 states said they spent less time and effort reporting to HHS on block grant activities than they had under the prior categorical programs. Officials from two of the six states said that the block grant reporting requirement positively affected their ability to manage MCH services. The elimination of HHS' Bureau of Common Reporting Requirements and other annual data reports were cited as examples of reduced reporting requirements. Program officials in five states said they spent about the same amount of time and effort reporting to the federal government under block grants as they did under the prior categoricals, and one state said it was unable to judge. Only one state official believed that more time had been spent

on reporting because performance reports had to be submitted annually, whereas categorical reporting had been done much less frequently.

QUANTIFICATION AND COMPARISON OF ADMINISTRATIVE COSTS NOT POSSIBLE

As discussed in the two previous sections, states have experienced a mixture of increased grant management responsibilities and administrative simplifications since the implementation of block grants. Some believed that the administrative savings associated with the block grant approach could offset some federal funding reductions.

Others were less optimistic, but many believed that fewer layers of administration, better state and local coordination of services, fewer federal regulations and requirements, and better targeting of services could lead to cost savings. However, while much was said about the administrative cost savings that might be achieved, specific savings could not be quantified. Essentially, two types of data must exist to determine specific administrative cost savings:

--uniform administrative cost data at the state level based on uniform state definitions of administrative costs and

--comprehensive baseline data on prior programs both at the state and federal level.

State approaches to defining administrative costs differ widely

Six of the 13 states have written definitions of administrative costs that apply to the MCH block grant. Officials in three other states provided unwritten definitions, and the remaining four states have no definition. The definitions range from very vague and general to very detailed, with specific administrative cost items being identified. In addition, the types of costs included in the definitions vary greatly. Furthermore, only three states have definitions which identify costs for subrecipients. The nine states which defined administrative costs did it in a manner essentially consistent with Office of Management and Budget Circular A-87, Cost Principles for State and Local Governments.

In addition to the differences in administrative cost definitions, states use varying procedures for computing and documenting administrative costs, and a few states have no such procedures. Also, none of the 13 states have provided subrecipients with instructions for computing administrative costs.

At the time of our review, 5 of the 13 states had information on their 1982 administrative costs. Of those five states, we found that three were within the 7.5-percent recommended ceiling for the MCH block grant[3] and one exceeded it slightly. Another state estimated it would exceed the recommended limit, but that state included administrative costs which may be attributable to a program not part of the block grant. The remaining eight states had no information on their 1982 administrative costs for the MCH block grant. Pennsylvania was one of the three states within the recommended ceiling and had calculated administrative costs to be 4.5 percent. State officials told us they had interpreted the recommended ceiling included in the congressional conference report to apply to total state program outlays, rather than block grant funds only. Administrative costs would have been 12.7 percent if they had been calculated on the basis of MCH block grant funds only.

Comprehensive baseline data on prior categorical programs not available

The ability to measure savings is also hampered by the lack of comprehensive baseline data on the cost of administering the prior categorical programs. As discussed in chapter 2, block grant funds are usually treated as a funding source for state programs and, as such, are often integrated with state and other funds. At the state level, only 4 of the 13 states had specific information on the cost of administering those categorical programs that had previously been administered by the state. With regard to costs incurred at the federal level, program officials indicated that it would be very difficult to determine the administrative costs of the prior categorical programs administered at that level because no comprehensive pre-block data exist. Specifically, offices having responsibility for more than one categorical program were unable to identify the costs associated with any one program.

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[3]Although the MCH block grant legislation does not contain a limit on administrative costs, the conference report accompanying the Omnibus Budget Reconciliation Act of 1981 states that:

> "The conferees intend that States, and if a State chooses to pass funds through those localities, would at least hold their administrative expenses to 7.5 percent of the total outlays, and expect that they economize even further to the maximum extent possible." H.R. Rep. No. 97-208, 97th Cong., 1st Sess. 790 (1981).

The inability to specifically determine administrative costs is not something new. In 1978, we reported (GGD-77-87, dated Feb. 14, 1978) that despite growing interest in the administrative cost question, there was no reporting system available to provide information on the amount of dollars or staff resources used to administer individual assistance programs. As a result, attempts to analyze and compare the efficiency of various administrative methods met with limited success. Essentially, that condition prevails for the MCH block grant today.

State officials provide varying perceptions about administrative costs

While there are some indicators of administrative simplification and management improvement, quantifying any overall administrative cost savings appears impractical. Therefore, the best indicators of administrative cost savings are probably the perceptions of state officials who have had the greatest contact with administering both the block grant and the prior categorical programs. These perceptions tend to support the notion that although the block grants have simplified some areas of administration, they have brought added responsibilities in other areas, and the specific impact cannot be quantified. For example:

--A Kentucky state official said that the MCH block grant has had an impact on the state's cost of administration, but it cannot be quantified. He noted that the block grant streamlined many federal reporting requirements, and its flexibility allows more funds to go toward direct services.

--A Mississippi state official said that administrative costs under the MCH block grant are actually greater than those of the former categoricals. He noted that state officials must now interpret many regulations, arrange for audits, and manage other aspects formerly handled at the federal regional level. Additionally, because of the broad interest in block grants, state officials have devoted more time to responding to requests for information. The official also noted that even though states were given increased administrative responsibilities, the block grant did not provide additional funding for these responsibilities.

--A Massachusetts official said that MCH administrative costs have neither increased nor decreased as a result of the change from categorical to block grants.

CONCLUSIONS

State level organizational structures for MCH have changed little as a result of the block grant. Block grant responsibilities have generally been given to those state agencies which administered the prior categorical programs, although some organizational changes have been made to improve efficiency. Similarly, only limited changes have been made to the structure of the service provider network.

States carried out block grant management activities by establishing program requirements, monitoring, providing technical assistance, collecting data, and auditing. Although different approaches and emphases were noted among the states, there was considerable reliance on existing state procedures in a number of these areas and, accordingly, the additional responsibilities did not produce significant changes in management procedures.

The reduced federal requirements and the management flexibility associated with the block grant produced some indications of administrative simplification. Several states had standardized or changed administrative requirements, and improvements were made in planning and budgeting and the use of personnel. However, state officials had mixed reactions regarding the time and effort now being spent on preparing applications and reporting to the federal government. Despite some indications of administrative simplification, specific cost savings could not be quantified in a comprehensive manner. In addition, even state officials' perceptions regarding administrative cost savings varied.

CHAPTER 6

STATE ELECTED OFFICIALS AND CITIZEN GROUPS HAVE BECOME MORE INVOLVED IN PROGRAM DECISIONS UNDER THE BLOCK GRANT APPROACH

Under the MCH block grant, many governors and legislators became more involved in program decisions than they were under the prior categoricals. This increased involvement usually manifested itself through the state budget and appropriations process. These officials generally considered block grants to be more flexible and believed there was greater public participation than under the prior categorical approach.

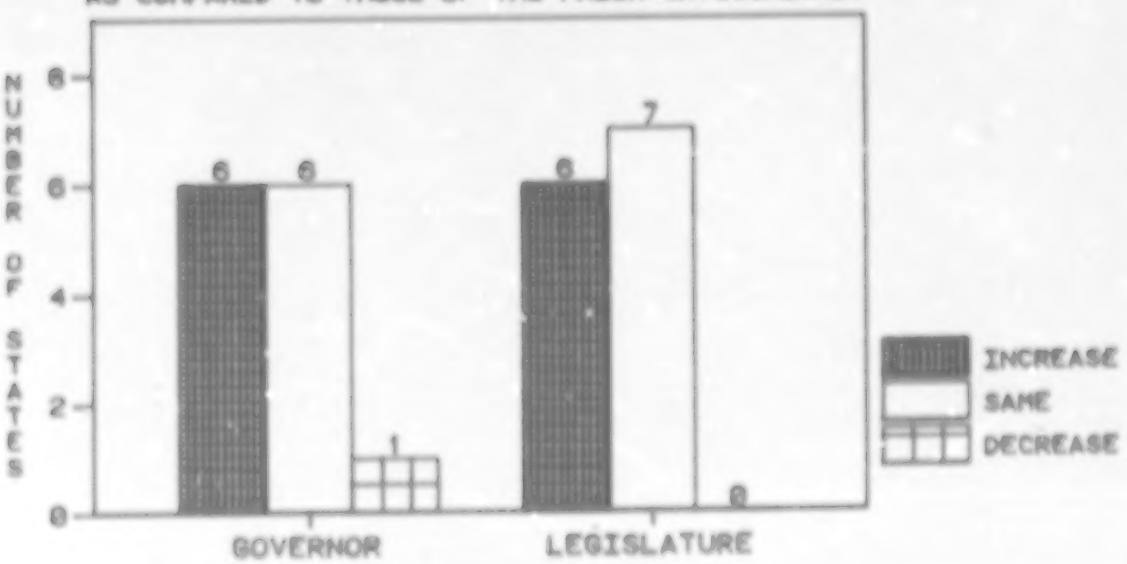
States took steps in addition to the basic federal requirements in obtaining citizen input. Beyond making available reports on the intended use of MCH funds, most states reported holding executive branch and legislative hearings and establishing advisory committees. These self-initiated mechanisms often influenced MCH program decisions.

While three-fifths of the interest group respondents we surveyed participated in public hearings, interest group satisfaction with state efforts to facilitate public input was mixed. Also, while most state officials believed the block grant approach was a more desirable way to fund MCH services, interest group respondents generally preferred the prior categoricals.

EXPANDED INVOLVEMENT OF GOVERNORS AND LEGISLATURES

Gubernatorial and legislative involvement in federally funded MCH programs has increased under the block grant approach in many states. Chart 6.1 shows that program officials in six states believe that their respective governor's involvement in MCH block grant program decisions has increased from the levels that existed under the prior categorical programs. Program officials in six states also believed their legislatures were more involved. Gubernatorial and legislative involvement in federally funded MCH programs now equals or exceeds involvement in state-funded programs in 9 of the 13 states.

CHART 6.1
STATE PROGRAM OFFICIALS' OPINIONS ABOUT THE CHANGE IN GOVERNOR AND LEGISLATURE INVOLVEMENT IN THE DECISIONS CONCERNING THE MCH BLOCK GRANT AS COMPARED TO THOSE OF THE PRIOR CATEGORICALS



Governors used several mechanisms to obtain information on or to exercise control over block grants. All relied on their opportunities to review budget submissions. About three-fourths also relied on the use of public hearings, advisory committees, and/or the review and approval of federal grant applications. Although these latter mechanisms were infrequently used in some states, others made great use of them. For example, in Mississippi, the governor created an advisory committee to oversee the block grant implementation and relied extensively on the recommendations made by this group. Governor's office representatives in 7 of the 13 states said the block grant approach, in general, encouraged them to change their use of information and control mechanisms in relation to their use under the categorical programs. These changes resulted in their redirecting and rethinking program priorities, becoming more involved in planning and reviewing programs, and increasing interagency cooperation. Only the governor's office in Texas plans further changes to these mechanisms in the near future. It is now holding smaller local hearings on the block grant before preparing its intended use report and holding statewide hearings.

Like the governors, the legislatures relied heavily on the state budget and appropriation processes to oversee block grants. Legislatures in all 13 states appropriate MCH block grant funds, and 11 state legislatures require the executive branch to report on federal grant programs, including the MCH block grant.

Legislative staffs in eight states said their legislatures are greatly involved in MCH block grant decisions. This was a considerable increase over the prior categorical programs where legislatures in only 2 of the 13 states noted a high degree of involvement. Also, legislatures in 4 of the 13 states changed MCH block grant plans or proposals by shifting funds among specific services or between blocks. Like most of the governors, most legislatures are not planning changes in their oversight mechanisms for the blocks.

Governor's office representatives and legislative officials identified a number of block grant characteristics which encouraged their involvement. The most commonly cited were:

--consolidation of related categorical programs,

--greater state authority to set program priorities, and

--the ability to transfer funds between blocks.

For example, Mississippi's governor transferred low-income energy block grant funds to MCH to fund a regional perinatal center to help reduce the state's high infant mortality rate.

Conversely, gubernatorial staff said that the block grant prohibitions and restrictions on the use of funds (as discussed on pp. 61 and 64) tended to negatively affect the governor's ability to oversee block grant planning and implementation. Similarly, legislative staff said these prohibitions and restrictions also tended to discourage legislative involvement.

STATE EFFORTS TO OBTAIN CITIZEN INPUT HAVE INCREASED

States must prepare and make public reports on their intended use of MCH funds and prepare annual reports on their MCH activities. Unlike some other block grants, formal mechanisms, such as public hearings, are not required. In addition to preparing required reports and making them public, all 13 states reported holding either executive or legislative hearings, and 10 states reported using one or more advisory committees. In

those states that sponsored executive hearings and/or used advisory groups, program officials in only three states believed the use of written comments was more important than the use of executive hearings or advisory groups in setting program priorities. Program officials in 11 of the 13 states reported that the level of public participation under the MCH block grant was greater, and in some cases much greater, than under the prior categorical programs.

All states prepared required reports

The law requires a state to prepare (1) a report describing its intended use of MCH funds and make it public in such a manner as to facilitate public comment and (2) an annual report on its MCH activities and also make this report publicly available. All 13 states said they made copies of their planned uses of MCH funds available to the public. Only 4 of the 13 states said that they made specific changes based on written comments they received on draft state plans. Among the methods of obtaining citizen input, interest groups were least satisfied with this mechanism for providing input into MCH program decisions.

Also, all states but Florida said they published a separate annual report on 1982 MCH activities. Florida included a summary of its 1982 activities in its 1983 planned use report, rather than issuing a separate report. Nine states sent or plan to send copies to state legislatures, five plan to send them to service providers and organizations representing the handicapped, and four to local government officials, private citizens, and organizations representing other public or private interest groups.

All states conducted executive or legislative public hearings

All 13 states reported holding public hearings on the MCH block grant by either the executive or legislative branches of government. None of the 13 states reported conducting executive hearings for any of the predecessor federal categorical grants. For MCH programs supported with fiscal year 1983 block grant funds, however, the executive branches in 10 of the 13 states held a combined total of 65 hearings on MCH, in conjunction with other block grants or related state programs.[1] No state indicated that it held separate hearings on the MCH block grant.

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[1]California, Colorado, and Iowa held no executive branch hearings on MCH but held legislative hearings.

While there were certain common features among the hearings, there were also differences. For example, the number of hearings ranged from 2 in Vermont to 12 each in Michigan and Florida. Most hearings were held outside of state capitals with an average of 68 persons attending. Eight of the 10 states holding executive branch hearings provided the public 2 to 4 weeks of advance notice of the hearings, primarily through notifications in newspapers and state mailing lists of interested parties. Nine of the 10 states that held executive hearings said they made draft plans publicly available prior to the hearings.

Sixteen legislative committees in 11 of the 13 states told us they held 44 hearings addressing the use of 1983 MCH block grant funds.[2] In contrast to executive hearings, most were held in the state capitals, and about 77 persons attended legislative hearings addressing MCH block grant activities. About half of the legislative hearings focused solely on block grants, including MCH. The remainder addressed MCH either as part of appropriations hearings for related state programs or in different contexts, such as fact finding in relation to overall federal funding cuts. Generally, the committees gave between 1 and 4 weeks of advance notice of the hearings. State mailing lists were the primary method of notifying interested groups, and the newspaper was the next most frequently used notification method.

Fifty-eight percent of the 249 MCH-related interest groups in our survey said they attended or testified at either executive or legislative hearings. A larger proportion of these respondents were satisfied rather than dissatisfied with most state efforts to facilitate their participation in hearings. However, although there were variances among the states, in total, 52 percent of the MCH interest groups indicated substantial dissatisfaction with the amount of information available prior to hearings and the timing of the hearings relative to the decisionmaking process.

Six state executive agencies plan to modify their hearings processes. For instance, Florida officials are going to change the format of their hearings, three states plan to hold fewer hearings, and California and Texas plan to hold more hearings.

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[2]Mississippi legislators participated in regional hearings jointly sponsored by the governor and the legislature; these hearings are identified as executive branch hearings in this report. Also, New York held its first separate MCH hearing for fiscal year 1984. Data are not available for any fiscal year 1983 hearings.

Additionally, Texas plans to hold its executive branch hearings earlier in the decisionmaking process.

Legislative committees in four states were also planning changes in their hearings procedures. Texas plans to hold its legislative hearings earlier, Kentucky plans to improve its method of notifying the public, and California plans to hold hearings outside the state capital. In addition, a New York state assembly committee plans to hold hearings on the MCH block grant for the first time.

Widespread use of advisory committees and task forces

Ten of the 13 states used a total of 19 advisory committees or task forces as part of their MCH decisionmaking process. None of these groups focused solely on MCH block grant funds. However, in 3 of the 10 states the advisory committees focused on MCH and other blocks; in 3 other states, MCH and other state programs; and in 2 states, they focused on MCH, other blocks, and other state programs. In the two remaining states, the focus of advisory groups went beyond block grants and related state programs.

The governor appointed advisory committee members in four states. In four others, they were appointed by state agency officials. In California, appointments to various MCH advisory committees were made by the governor, agency officials, the state legislature, and county officials; in Washington, two committees were appointed by agency officials and one by the governor. The most frequent members of advisory groups were representatives of service providers, technical experts, and the general public. Eight of the 10 states also included program officials, and 6 had legislative or governor's office representation.

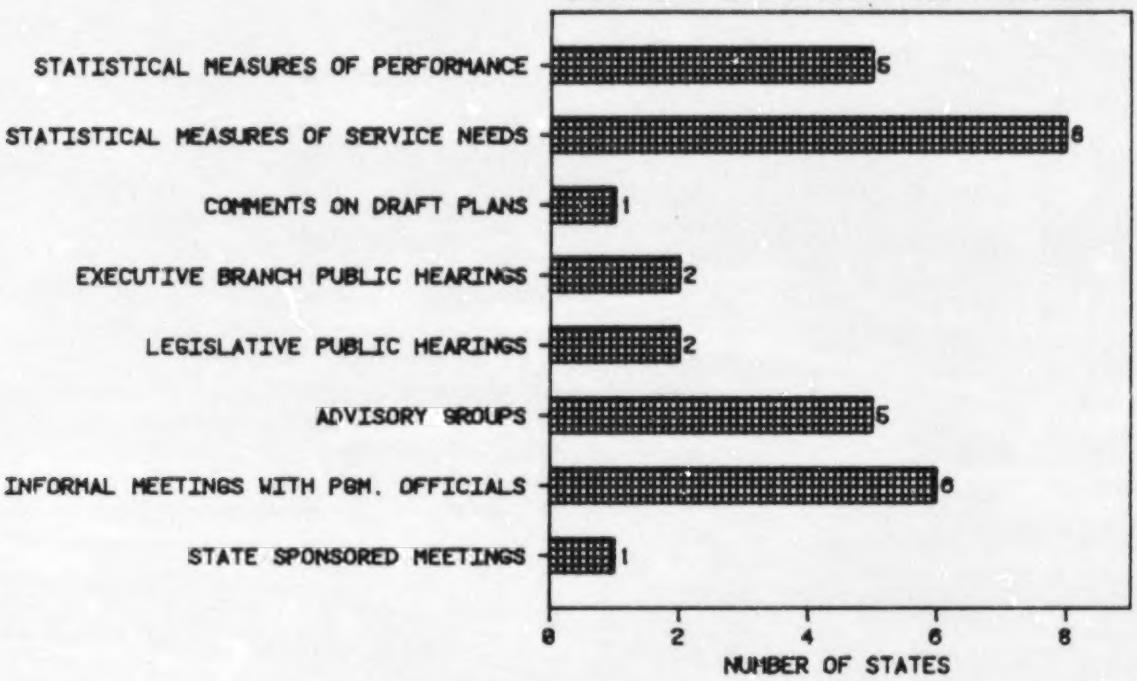
Eight states that used advisory groups in 1983 plan to continue them. In Massachusetts, one committee was dissolved and another retained. However, in Massachusetts and New York, where previous advisory groups had been dissolved, there are plans to reconvene or replace them.

Even though only 24 percent of the 249 MCH-related interest groups responding to our survey indicated they were actively involved in state-sponsored advisory groups, interest groups generally were more satisfied with state efforts to obtain input through this mechanism than they were with state efforts in obtaining comments. A greater share of respondents were satisfied rather than dissatisfied with both the role as well as the composition of advisory committees or task forces.

Role of citizen input in state MCH decisionmaking

As shown in chart 6.2, MCH program officials said that statistical measures of program performance and service needs, advisory committees, and informal consultation with state officials were the sources of information that had the greatest impact on decisions when setting priorities or objectives for programs supported by MCH funds. Only one state said the use of public comments on intended use plans was of great importance.

CHART 6.2
PROGRAM OFFICIALS' OPINIONS ABOUT THE SOURCES OF INFORMATION THAT WERE OF GREAT IMPORTANCE IN MCH BLOCK GRANT DECISIONS



Of the 10 states with advisory committees, 6 noted that their recommendations led to specific program decisions on their state's allocation of MCH funds.

Eight of the 13 states made program changes based on information received from the various citizen input mechanisms. For example:

--Legislative hearings in Florida led to revisions of the governor's proposals. Based on public input, the legislature included funding for two programs which were not included in the governor's initial proposals.

--Executive agency hearings in Massachusetts led to the incorporation of nutritional services into handicapped children's programs.

Program officials in four of the remaining states--New York, Pennsylvania, Texas, and Vermont--commented that the citizen input mechanisms did not influence or were uncertain as to the influence these mechanisms had on their MCH program decisions. Two of these states have no plans to substantially change their citizen input processes. In California, the executive branch supported recommendations made by an advisory committee, but the legislature failed to adopt them.

PERCEPTIONS OF INTEREST GROUPS AND STATE OFFICIALS ON BLOCK GRANTS

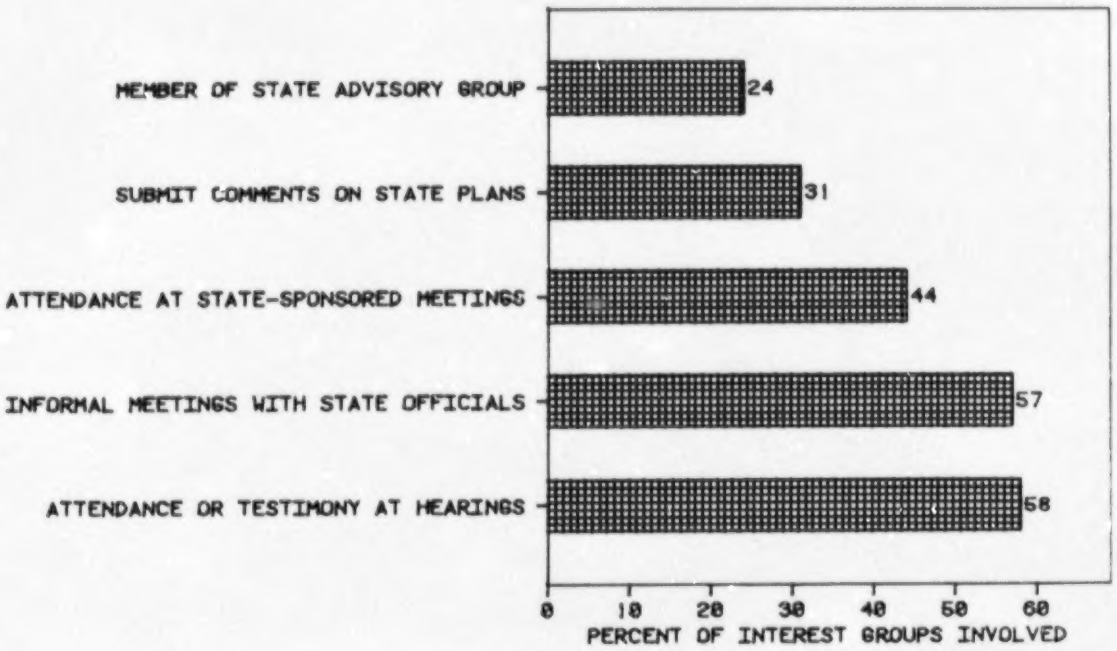
While many interest groups increased their activity with state officials under block grants, interest groups' satisfaction with state efforts to facilitate input into MCH program decisions was generally mixed. Also, they were evenly divided regarding their satisfaction with state responses to their concerns, but generally they believed state decisions on block grants adversely affected groups they represented. State officials were generally pleased with the block grant approach, while interest groups perceived block grants to be a less desirable way of funding MCH services.

Interest groups give mixed reaction on state input process and decisions

Over 40 percent of interest group respondents that focused on MCH told us they had increased their levels of activity with state legislatures and/or state executive agencies since block

grant implementation.[3] Most of these were statewide organizations involved in a wide range of activities to learn about or influence MCH programs. As shown in chart 6.3, interest groups actively participated in various aspects of the state citizen input process. Attending or providing testimony at hearings was the most widely used input process, with 58 percent of the 249 interest groups responding to our survey participating.

CHART 6.3
MCH INTEREST GROUP PARTICIPATION IN THE BLOCK GRANT INPUT PROCESS



[3]Of the 786 respondents to our survey of interest groups in the 13 states, 249 indicated they had some knowledge of MCH-funded programs. Not all 249, however, answered every question in our survey, and percentages are based on the total number of respondents to each question. The number of respondents to our questions ranged from 75 to 249. The actual numbers of respondents on a question-by-question basis are detailed in appendix XV.

Table 6.1 shows that more interest groups attended or testified at executive than legislative hearings.

TABLE 6.1

Percent of Interest Group Participation in Different Aspects of Hearing Process (out of 249 respondents)

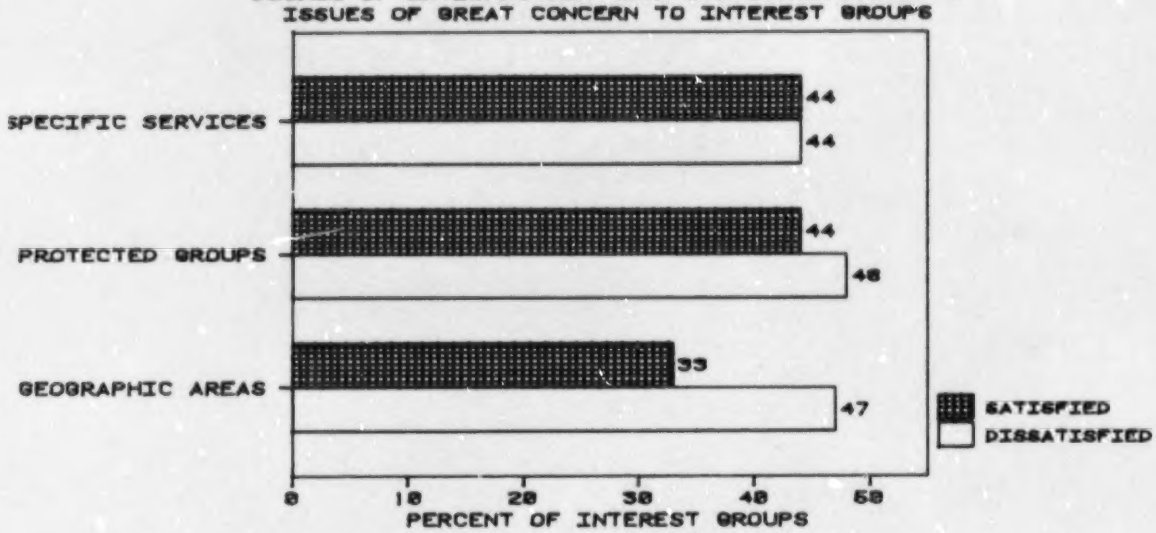
Aspect of process	Percent
Attendance at executive hearings	46
Attendance at legislative hearings	36
Testimony at executive hearings	24
Testimony at legislative hearings	17

There was no clear trend in interest group satisfaction or dissatisfaction with state methods for facilitating citizen input. The major area of satisfaction was with the accessibility of state officials for informal consultation (65 percent). The major areas of dissatisfaction related to the availability of information on the planned use of funds prior to hearings (52 percent) and the timing of hearings relative to states' allocation decisionmaking process (52 percent). Interest groups that actively participated in the states' overall processes through such activities as testifying, attending hearings, or submitting comments on state plans were more satisfied with state processes to obtain citizen input than those interest groups that were not actively involved.

Three issues most often cited as being of great or very great concern to interest groups were the need to maintain or increase funding for specific services (77 percent), for geographic areas within the state (51 percent), and for services to protected groups, such as minorities and handicapped (61 percent). Program officials also told us that they perceived a great concern about these three issues during the executive branch hearings.

As shown in chart 6.4, interest group responses were fairly evenly divided concerning their satisfaction or dissatisfaction with state responses to the need to maintain or increase funds for specific services or protected groups. However, they were less satisfied with state efforts to maintain or increase funds for specific geographic areas. Also, 54 percent of the interest group respondents believed the changes states made to programs supported with the MCH block grant funds adversely affected the groups or individuals they represented. Only 28 percent of the interest groups viewed state changes favorably. The remaining groups said there was no impact.

CHART 6.4
DEGREE OF SATISFACTION WITH STATE RESPONSES TO ISSUES OF GREAT CONCERN TO INTEREST GROUPS



State officials and interest groups have different perceptions of block grant approach

Program officials in 12 of the 13 states said the MCH block grant provided them more flexibility than prior categorical programs. Gubernatorial staff in 8 of the 13 states agreed. Legislative leaders in seven states believed block grants, in general, were more flexible than the prior categorical programs. Also, MCH program officials responsible for the day-to-day block grant administration in 9 of the 13 states believed that federal block grant requirements are less or much less burdensome than those of the prior categorical programs.

State officials generally believed the block grant approach was a more desirable funding mechanism when compared to the categorical approach. Legislative leaders in 10 of the 13 states and gubernatorial staffs in 10 of the 11 states that responded said block grants, in general, were a more desirable approach to funding programs than the categorical approach. In addition, MCH program officials in 10 of the 12 states that responded also believed the block grant approach for MCH programs

was more desirable. Of the 36 legislative leaders that responded in the 13 states, 29 individuals or 81 percent believed the block grant approach was more desirable. Only four state officials--three legislative leaders and one program official--believed block grants were less desirable. The others had no opinion or said there was little or no difference between the approaches.

Interest groups, on the other hand, did not generally perceive the block grant approach to be a desirable method of funding MCH programs. Only 26 percent said the block grant approach was more desirable, while 54 percent saw the approach as less or much less desirable. The remaining 20 percent saw little or no difference. Interest groups found the block grant approach to be less desirable than the prior categoricals generally because (1) they perceived state block grant decisions had adversely affected those groups or individuals they represented, (2) they were not active in providing citizen input, and (3) they were dissatisfied with state responses to issues they considered to be of concern to themselves, such as increasing or maintaining funding to specific geographic areas.

While interest groups and state officials had differing views on the desirability of the block grant, both expressed concern about the federal funding reductions that accompanied the block. In our opinion, it was often difficult for individuals to separate block grants--the funding mechanism--from block grants--the budget-cutting mechanism. Accordingly, officials in several states experiencing funding cuts commented that the advantages of their expanded flexibility were somewhat diminished by the reduced federal funding, and selected interest groups in those states were concerned about the implications that reduced funding held for the organizations and individuals they represented.

CONCLUSIONS

The increased flexibility of the block grant approach, particularly the opportunity to set priorities for previously directly federally funded programs, in our opinion has contributed to the increased role of the governors and legislatures. This increased involvement of state elected officials has been accompanied by increased citizen involvement in the decisionmaking process for MCH programs. We found states took steps in addition to basic federal requirements to obtain public input, and many states used input from advisory committees when making program decisions.

Interest groups were generally pleased with their access to state officials and the role and composition of advisory committees but provided a mixed reaction in their assessments of other aspects of the state's citizen input process. Many were dissatisfied with the availability of information prior to hearings and the timing of hearings in relation to when state decisions were made. Also, they had a mixed reaction regarding the adequacy of state responses to their primary concerns.

In general, state officials found the block grant approach to be more flexible, less burdensome, and viewed it as a more desirable method of funding MCH services. On the other hand, interest groups generally viewed it to be a less desirable method of funding MCH services and believed that state changes to programs supported with block grant funds negatively affected the groups they represented.

DESCRIPTION OF GAO'S

DATA COLLECTION METHODOLOGY

To obtain information concerning the implementation and administration of block grants in 13 states, we collected data from two sets of sources:

1. Individuals or organizations having interest in a single block grant, such as the state office that administers the block grant and

2. Individuals or organizations potentially having interest in more than one block grant, such as groups within the state legislature.

In some instances we obtained data directly from records available at organizations we visited; however, most of the data were provided to us by individuals or organizations. Most data collection took place during the period of January to August 1983.

We developed four data collection instruments for use in obtaining information from the first set of sources referred to above and five for use in obtaining information from the second set of sources. The instruments we used to obtain information from sources having interest in a single block grant were:

--Program Officials Questionnaire.

--Financial Information Schedules.

--State Audit Guide.

--Service Provider Data Collection Guide.

Almost identical versions of the Program Officials Questionnaire were used for all block grants we reviewed. The other three instruments listed above were to a much greater degree tailored to the specific block grant.

Questionnaires were used to obtain information from sources with potential interest in more than one block grant. The five respondent groups for these questionnaires were:

--governors' offices,

--state legislative leadership,

--state legislative committees,

--state legislative fiscal officer(s), and

--public interest groups.

The approach we generally took with these questionnaires was to ask about the respondent's specific experience with the block grants and then ask some questions about general impressions and views concerning the block grant concept.

The primary focus of our study was at the state level; thus, most of our data collection took place there. Even when collecting data from other than the state level, state implementation and administration remained our major interests. The questions in the Public Interest Groups Questionnaire concerned the group's views as to the manner in which the state implemented and administered each block grant. The Service Provider Data Collection Guide was used not to obtain comprehensive data from the service provider level, but rather to identify some of the implications, for service providers, of state policies and practices in block grant implementation.

The questionnaires were pretested and subjected to external review prior to their use. The extent of pretest and review varied with the questionnaire, but in each case one or more state officials or organizations knowledgeable about block grants received copies of the questionnaire and provided their comments on it.

The Financial Information Schedules were discussed with other organizations that had obtained similar information at the state level in the past. The topics to be included in the Service Provider Data Collection Guide were discussed with service providers before the final instrument was produced.

The sections below present a detailed description of the contents of each of the data collection instruments, as well as information on the source of the data and the method by which the instrument was administered.

PROGRAM OFFICIALS QUESTIONNAIRE

Content

This questionnaire was designed to elicit information about the administration of the block grant. It asked state program officials about:

--the ways in which the state established priorities on program objectives,

--the procedures used to obtain the views of citizens and other interested groups,

--the scope of the state's data collection efforts,

--the extent to which technical assistance was provided to state and local recipients,

--the state's procedures and practices for monitoring service providers, and

--the state's general impressions concerning block grants.

Source of information

The questionnaires were completed by senior level officials in the program offices primarily responsible for administering the block grant in the 13 states included in our study. We specified in the questionnaire that the responses to the questionnaire should represent the official position of the program office.

Method of administration

Our field staff identified the senior program official in each state and delivered the questionnaire to the office of that official. The state program official was asked to complete the questionnaire with help, if necessary, from other staff and return the questionnaire to our representative who delivered it. A series of selective follow-up questions were developed to obtain additional information, primarily when certain responses were given.

FINANCIAL INFORMATION SCHEDULES

Content

The purpose of these schedules was to obtain the best available data on how states were spending block grant funds in addition to other sources of funds on MCH program areas. These schedules show for state fiscal years 1981 to 1983 the amount of expenditures for each predecessor categorical program area from:

--Federal categorical funds going through the state government and the amounts received by directly funded grantees.

--Block grant funds.

--Secretary's set-aside funds.

--Other MCH-related federal funds.

--MCH-related state funds.

--MCH-related local cash match.

--Other funds, such as fees for services and copayments, or reimbursements from third parties, such as Medicaid.

In addition, using similar categories we collected expenditure data at the state level for individual service providers receiving federal funds directly or through the states.

We used expenditure data rather than award data to more accurately reflect the level of activity in each state and program area and to address the effect of categorical outlays during block grant years. In addition, these data were generally collected on a state fiscal year basis because this was the standard accounting period in most states. Texas is an example where expenditure data were collected on a federal fiscal year basis, however, since this was the format in which the data were most readily available. Texas' state fiscal year only varies from the federal fiscal year by 1 month.

Source of information

The expenditure data were obtained from program and budget information available at the state level.

In some instances, actual expenditure figures were not available and, as a result, estimated figures were provided. In these cases, however, state officials agreed that the figures provided represented the best available information at the time we completed our fieldwork.

At times, individual service providers had to be contacted for expenditure data. We also consulted with officials from the Association of State and Territorial Health Officials, the Urban Institute, and HHS on the design of the financial information schedules because of their knowledge and ongoing work in these areas.

Method of administration

Our staff worked with state program and budget officials to complete our pro forma expenditure schedules.

STATE AUDIT GUIDE

Content

Our field staff used this audit guide to collect information on the state administration and management of the MCH block grant. The areas covered in this guide included:

--Reviewing the overall state health planning process and determining how planning for MCH block grant funds and programs fit into this process.

--Identifying the administrative structure used by the state to deliver MCH services.

--Reviewing program areas supported with MCH funds to determine and analyze expenditure trends by programs and sources of funding.

--Identifying types of services provided within each MCH program area and changes made to services provided since the state adopted the block grant.

--Identifying changes made to the types of service providers and beneficiaries of services since the state adopted the block grant.

--Identifying changes made to the methods for distributing federal categorical and block grant funds.

Source of information

The information was obtained from state documents and through interviews with state officials.

Method of administration

A detailed audit guide was used by our field staff to obtain this information. Follow-up meetings were held with state officials for further information or clarification of data.

SERVICE PROVIDER DATA COLLECTION GUIDE

Content

This guide was used by our field staff to collect information concerning services provided through the use of block grant and other funds. The areas covered in this guide included:

--Descriptive information about the service provider.

--Sources of service provider funding.

--Scope of specific services provided.

--Methods of service delivery.

--Information about clients served by the provider.

Source of information

A total of 44 service providers were visited by our field staff in the 13 states. Those service providers were judgmentally selected in order to provide some coverage by range of (a) types and sizes of providers (e.g., state, private, nonprofit), (b) types of MCH services provided, and (c) location in the state (urban and rural areas). In our selection, we attempted to include, where appropriate, at least three service providers from each state we visited and at least three service providers for each of the prior categorical programs consolidated into the MCH block grant.

The service providers were generally selected from a list provided by the state health agencies.

Method of administration

The instrument was completed on-site by our field staff. Interviews with service provider officials and staff and review of documents, such as annual reports and internal audits, served as the basis for the data recorded on the instrument.

GOVERNOR'S OFFICE QUESTIONNAIRE

Content

This questionnaire focused on the role played by the governor and his office in implementing and administering the block grants. Questions included were:

--The extent of the governor's involvement in the decision-making process regarding block grant funding and administration.

--What the governor did to obtain information or exercise control over the setting of state program priorities.

--Whether there are any changes anticipated in the way in which the governor will exercise control in the future.

--If additional federal technical assistance would have been useful.

--What the governor's general impression was about block grants.

Source of information

The questionnaire was completed by the governor or a representative designated by the governor.

Method of administration

The questionnaires were mailed directly to the governors, with all governors or their designated representative responding. When complete, the questionnaires were returned to one of our representatives.

STATE LEGISLATIVE LEADERSHIP QUESTIONNAIRE

Content

This questionnaire was used to obtain information about the perceptions of state legislative leaders concerning block grants. The questions asked legislative leaders included:

--How block grants affected the way in which the state legislature set program priorities and funding priorities.

--What the major benefits were of funding programs through block grants.

--How block grants could be improved.

--Their general impressions about block grants.

Source of information

We compiled a list of legislative leaders based on a publication by the Council of State Governments, State Legislative Leadership; Committees and Staff, 1983-84. Generally there were four per state: the presiding officer of the senate, the senate minority leader, the speaker of the house, and the house minority leader. A total of 48 questionnaires were administered, and 40 completed questionnaires were returned for a response rate of 83 percent.

Method of administration

Our staff delivered the questionnaire to the offices of the legislative leaders in each state. We asked that they complete the questionnaire and return it to our representative who delivered it.

STATE LEGISLATIVE COMMITTEES QUESTIONNAIRE

Content

The questionnaire requested information about public hearings concerning block grants held by committees of the state legislature in the 13 states. Questions included were:

--How many hearings were held and where.

--Who sponsored the public hearings.

--What mechanisms were used to inform citizens that hearings were being held.

--Who testified at the hearings.

--What were the concerns of those testifying.

Source of information

Our field staff attempted to identify those committees in each state that held public hearings for 1983 concerning block grants. The questionnaires were completed by senior committee staff responsible for organizing public hearings on block grants. Twenty-eight committees received questionnaires and all completed and returned them.

Method of administration

Our staff delivered the questionnaire to each legislative committee that held public hearings for 1983 block grants. A senior committee staff member was requested to complete the questionnaire and return it to our staff member who delivered it. We followed up on selected questions for additional information.

STATE LEGISLATIVE FISCAL OFFICER QUESTIONNAIRE

Content

The purpose of this questionnaire was to obtain information about the procedures used by the state legislatures to control and monitor block grant programs. Specifically, we asked:

--What control or monitoring mechanisms the state legislature has and whether they have changed since block grants were implemented by the state.

--How block grant funds are appropriated.

--Whether public hearings led to changes in the use of block grant funds.

--What role the legislature played in changing executive agencies' block grant plans or proposals.

--The fiscal officer's general impressions about block grants.

Source of information

Legislative fiscal officers are generally the directors of the permanent, professional staffs of state legislatures. To identify the appropriate staff persons to whom we should direct our questionnaire, we sought the assistance of the National Conference on State Legislatures, the National Association of State Fiscal Officers and the Council of State Governments.

Method of administration

Our staff delivered 19 questionnaires to fiscal officers in the 13 states. Seventeen were completed and returned, for an 89-percent response rate. We followed up on questions for additional information, as needed.

PUBLIC INTEREST GROUP QUESTIONNAIRE

Content

This questionnaire asked various public interest groups about:

--Their involvement with and perceptions of block grants.

--Perceptions about the state's efforts to solicit and incorporate citizen input into state program decisions made on block grants.

--Their views as to the impact of changes made by the state on those represented by the group.

--Their perceptions of changes in civil rights enforcement as a result of block grants.

Source of information

The names and addresses of interest groups were obtained from several sources. Initially we contacted about 200 national level organizations and asked if they had state affiliates that might have dealt with the implementation of the block grants. From those that responded affirmatively, we requested the names and addresses of their state affiliates. The list of 200 national level organizations was compiled from lists developed by GAO staff, from mailing lists of organizations interested in specific block grants compiled by HHS, and from the staff of a private organization with extensive knowledge about block grants.

This list was supplemented, where possible, by lists of interest groups compiled from attendance rosters kept by state agencies during the course of their public hearings. The availability and usefulness of these lists varied by state.

Once an initial list was compiled, we sent it to our staff in each of the 13 states. They, in turn, showed these lists to state officials involved with the block grants and to a small, diverse group of respondents on the lists. These groups provided corrections and recommended additions of groups that they felt were active in block grant implementation but were not on the list we had initially compiled.

The results of the selection process were not intended to be viewed as either the universe of public interest groups knowledgeable about block grants or a representative sample of public interest groups for any state or block grant. We believe, however, the interest groups we contacted provided a diverse cross section of organizations knowledgeable about the MCH block grant implementation.

Method of administration

Questionnaires were mailed to the identified public interest groups with an enclosed, stamped, pre-addressed envelope. A follow-up letter and questionnaire were sent to those who failed to respond within 3 weeks after the initial mailing.

Of the 1,662 groups on our final list, 786 returned completed questionnaires, for a 47 percent response rate. Of the completed questionnaires, 249 indicated that they had at least some knowledge of the implementation of the MCH block grant in the state in which their organization was located.

PERCENTAGE OF TOTAL MCH EXPENDITURES DERIVED FROM FEDERAL, STATE, AND OTHER SOURCES

State	Federal sources			State and other sources		
	1981	1982	1983	1981	1982	1983
Colorado	57	54	58	43	46	42
Florida	33	25	23	67	75	77
Iowa	76	72	71	24	28	29
Kentucky	47	46	39	53	54	61
Massachusetts	60	61	58	40	39	42
Michigan	42	40	40	58	60	60
Mississippi	59	47	48	41	53	52
Pennsylvania	40	41	40	60	59	60
Texas	50	35	32	50	65	68
Vermont	46	43	38	54	57	62
Washington	69	67	62	31	33	38
California		28	28		72	72
New York		39	38		61	62

EXPENDITURE OF FEDERAL CATEGORICAL, BLOCK GRANT, AND SECRETARY'S SET-ASIDE FUNDS

State	1981	1982	1983	Change[a] $	Change[a] %
	(000 omitted)				
Colorado	$ 7,580	$ 7,106	$ 6,586	$ (994)	(13)
Florida	13,263	11,064	10,361	(2,902)	(22)
Iowa	5,736	5,254	5,028	(708)	(12)
Kentucky	6,747	7,384	7,042	295	4
Massachusetts	9,927	9,995	10,054	127	1
Michigan	13,560	12,521	13,600	40	b
Mississippi	7,502	6,682	7,081	(421)	(6)
Pennsylvania	20,271	19,571	18,848	(1,423)	(7)
Texas	21,703	16,740	18,158	(3,545)	(16)
Vermont	1,098	1,153	1,155	57	5
Washington	7,636	7,674	7,488	(148)	(2)
Total	$115,023	$105,144	$105,401	$(9,622)	(8)
California		$20,912	$24,212	$3,300	16
New York		30,134	29,805	(329)	(1)
Total		$51,046	$54,017	$2,971	6

[a]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

[b]Less than 1 percent increase.

EXPENDITURE OF MCH-RELATED STATE FUNDS

State	1981	1982	1983	Change[a] $	Change[a] %
	(000 omitted)				
Colorado	$ 4,637	$ 5,156	$ 3,498	$(1,139)	(25)
Florida	28,974	33,326	37,456	8,482	29
Iowa	1,725	1,710	1,716	(9)	(1)
Kentucky	11,508	12,57[illegible]	14,977	3,469	30
Massachusetts	6,771	6,564	7,480	709	10
Michigan	14,180	15,550	15,495	1,315	9
Mississippi	3,119	3,333	3,424	305	10
Pennsylvania	31,224	28,481	28,828	(2,396)	(8)
Texas	20,899	27,932	38,638	17,739	85
Vermont	1,823	2,294	3,001	1,178	65
Washington	3,373	3,763	4,599	1,226	36
California		37,960	43,539	5,579	15
New York		22,179	22,205	26	[b]

[a]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

[b]Less than 1 percent increase.

EXPENDITURE OF OTHER FUNDS[a]

State	1981	1982	1983	Change[b] $	Change[b] %
	----------(000 omitted)----------				
Colorado	$1,742	$ 1,697	$ 2,033	$ 291	17
Florida	7,019	11,154	11,724	4,705	67
Iowa	113	310	334	221	196
Kentucky[c]					
Massachusetts[c]					
Michigan	5,492	4,700	6,156	664	12
Mississippi	2,284	4,367	5,172	2,888	126
Pennsylvania[c]					
Texas	1,073	3,304	701	(372)	(35)
Vermont[c]					
Washington	37	38	25	(12)	(32)
California		18,374	20,483	2,109	11
New York		31,222	32,224	1,002	3

[a]Other funds include local matching funds, fees for services, copayments and reimbursements such as from Medicaid. Although these amounts represent the best available information at the state level, some officials noted these amounts may not be complete.

[b]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

[c]Kentucky, Pennsylvania and Vermont did not report complete data for all 3 years and are excluded from our analysis. Massachusetts has not required local cash matches or fees, and provided no data on expenditure of other funds.

EXPENDITURES FOR CRIPPLED CHILDREN'S SERVICES

State	1981	1982	1983	Change[a] $	Change[a] %
	----------(000 omitted)----------				
Colorado	$ 4,316	$ 4,188	$ 3,795	$ (521)	(12)
Florida	24,741	30,333	33,867	9,126	37
Iowa	3,536	3,314	3,252	(284)	(8)
Kentucky	5,866	6,659	7,035	1,169	20
Massachusetts	4,474	5,860	5,816	1,342	30
Michigan	21,498	21,128	22,483	985	5
Mississippi	3,013	2,626	2,863	(150)	(5)
Pennsylvania	9,814	8,292	9,870	56	1
Texas	24,053	28,481	34,915	10,862	45
Vermont	611	825	916	305	50
Washington	4,040	4,507	5,357	1,317	33
Total	$105,962	$116,295	$130,169	$24,207	23
California		$ 53,864	$ 58,610	$ 4,746	9
New York		18,614	15,822	(2,792)	(15)
Total		$ 72,478	$ 74,432	$ 1,954	3

[a]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

EXPENDITURES FOR MATERNAL AND CHILD HEALTH RESEARCH, TRAINING, AND SERVICES

State	1981	1982	1983	Change[a] $	Change[a] %
	(000 omitted)				
Colorado	$ 9,484	$ 9,598	$ 8,138	$(1,346)	(14)
Florida	26,394	27,594	28,356	1,962	7
Iowa	3,080	2,767	2,800	(280)	(9)
Kentucky	14,646	15,161	15,720	1,074	7
Massachusetts	9,230	7,632	8,527	(703)	(8)
Michigan	10,637	10,416	10,633	(4)	[b]
Mississippi	9,933	11,584	13,569	3,636	37
Pennsylvania	37,993	34,502	32,472	(5,521)	(15)
Texas	16,052	15,910	17,091	1,039	6
Vermont	2,472	2,967	3,690	1,218	49
Washington	6,135	5,666	5,815	(320)	(5)
Total	$146,056	$143,797	$146,811	$ 755	1
California		$ 19,545	$ 23,874	$ 4,329	22
New York		59,293	63,415	4,122	7
Total		$ 78,838	$ 87,289	$ 8,451	11

[a]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

[b]Less than 1 percent decrease.

APPENDIX VIII

EXPENDITURES FOR LEAD-BASED PAINT POISONING PREVENTION

State	1981	1982	1983	Change[a] $	Change[a] %
	(000 omitted)				
Colorado	$ 0	$ 0	$ 0	$ 0	b
Florida	0	0	0	0	b
Iowa	242	195	119	(123)	(51)
Kentucky	291	193	170	(121)	(42)
Massachusetts	1,901	1,375	1,508	(393)	(21)
Michigan	601	410	492	(109)	(18)
Mississippi	0	0	0	0	b
Pennsylvania	741	743	870	129	17
Texas	119	0	0	(119)	(100)
Vermont	0	0	0	0	b
Washington	0	0	0	0	b
Total	$3,895	$2,916	$3,159	$ (736)	(19)
California		$ 14	$ 0	$ (14)	(100)
New York		3,868	2,055	(1,813)[c]	(47)
Total		$3,882	$2,055	$(1,827)	(47)

[a]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

[b]Percentage change cannot be calculated.

[c]New York's funding change may be overstated, although the declining trend is real. Part of this decline resulted from a change in the way the program was accounted for in 1983.

EXPENDITURES FOR SUDDEN INFANT DEATH SYNDROME (SIDS)

State	1981	1982	1983	Change[a] $	Change[a] %
	(000 omitted)				
Colorado	$ 57	$ 43	$ 37	$ (20)	(35)
Florida	78	90	64	(14)	(18)
Iowa	43	40	41	(2)	(5)
Kentucky	62	52	40	(22)	(35)
Massachusetts	120	180	158	38	32
Michigan[b]					
Mississippi	0	18	22	22	c
Pennsylvania	118	125	220	102	86
Texas	170	18	0	(170)	(100)
Vermont	20	19	23	3	15
Washington[d]	117	111	85	(32)	(27)
Total	$785	$696	$690	$ (95)	(12)
California		$120	$ 0	$(120)	(100)
New York		300	90	(210)[e]	(70)
Total		$420	$ 90	$(330)	(79)

[a]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

[b]Michigan is excluded due to lack of comparable data.

[c]Percentage change cannot be calculated.

[d]Total SIDS expenditures could not be identified because all related costs were not recorded separately and were not readily available. The identified expenditures include data from one service provider during the 3-year period.

[e]New York funding change may be overstated, although the declining trend is real. Part of this decline resulted from a change in the way the program was accounted for in 1983.

EXPENDITURES FOR ADOLESCENT PREGNANCY PREVENTION SERVICES

State	1981	1982	1983	Change[a] $	Change[a] %
	(000 omitted)				
Colorado	$ 0	$ 170	$ 460	$ 460	[b]
Florida	600	545	558	(42)	(7)
Iowa	0	0	0	0	[b]
Kentucky[c]	0	0	0	0	[b]
Massachusetts	423	534	637	214	51
Michigan	314	280	200	(114)	(36)
Mississippi	74	102	88	14	19
Pennsylvania[d]	0	0	0	0	[d]
Texas	525	302	240	(285)	(54)
Vermont	140	130	96	(44)	(31)
Washington	160	218	305	145	91
Total	$2,236	$2,281	$2,584	$ 348	16
California		$ 716	$ 782	$ 66	9
New York		1,175	1,092	(83)	(7)
Total		$1,891	$1,874	$ (17)	(1)

[a]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

[b]Percentage change cannot be calculated.

[c]Services are provided through the maternal and child health services program.

[d]Because Pennsylvania reported 1981 adolescent pregnancy expenditures as part of its maternal and child health services expenditures, comparing 1983 expenditures to 1981 would be misleading. Therefore, its 1983 expenditures of $900,000 have been included in its maternal and child health services program.

EXPENDITURES FOR GENETIC DISEASE TESTING AND COUNSELING SERVICES

State	1981	1982	1983	Change[a] $	Change[a] %
	(000 omitted)				
Colorado	$ 440	$ 369	$ 322	$ (118)	(27)
Florida	530	754	724	194	37
Iowa	495	680	622	127	26
Kentucky	0	126	249	249	[b]
Massachusetts	93	255	344	251	270
Michigan	393	462	425	32	8
Mississippi	102	164	81	(21)	(21)
Pennsylvania	598	564	500	(98)	(16)
Texas	569	591	449	(120)	(21)
Vermont	74	73	74	0	0
Washington	507	566	566	59	12
Total	$3,801	$4,604	$4,356	$ 555	15
California		$3,577	$4,666	$1,089	30
New York[c]					
Total		$3,577	$4,666	$1,089	30

[a]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

[b]Percentage change cannot be calculated.

[c]New York is excluded because comparable data were not available. Total expenditures for 1983 were $965,000; although state officials indicated no significant changes between 1982 and 1983, 1982 expenditures could not be provided.

EXPENDITURES FOR COMPREHENSIVE HEMOPHILIA DIAGNOSTIC AND TREATMENT CENTERS

State	1981	1982	1983	Change[a] $	Change[a] %
	(000 omitted)				
Colorado	$ 141	$ 147	$ 134	$ (7)	(5)
Florida	0	0	0	0	[b]
Iowa	192	257	270	78	41
Kentucky[c]	0	0	0	0	[b]
Massachusetts[d]	166	187	215	49	30
Michigan	182	221	159	(23)	(13)
Mississippi	0	0	0	0	[b]
Pennsylvania	1,511	1,510	1,652	141	9
Texas	361	422	194	(167)	(46)
Vermont	0	0	0	0	[b]
Washington[c]	0	0	0	0	[b]
Total	$2,553	$2,744	$2,624	$ 71	3
California		$ 467	$ 650	$ 183	39
New York		480	381	(99)	(21)
Total		$ 947	$1,031	$ 84	9

[a]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

[b]Percentage change cannot be calculated.

[c]Provided through other MCH programs.

[d]This amount is for one service provider. Otherwise, this program is funded and administered through other MCH block grant programs.

EXPENDITURES FOR SERVICES FOR DISABLED CHILDREN RECEIVING SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS

State	1981	1982	1983	Change[a] $	Change[a] %
	(000 omitted)				
Colorado[b]	$ 0	$ 0	$ 0	$ 0	[c]
Florida[b]	1,409	382	0	(1,409)	(100)
Iowa[b]	0	0	0	0	[c]
Kentucky[d]	9	164	275	266	2,956
Massachusetts[d]	644	917	461	(183)	(28)
Michigan[e]	356	558	951	595	167
Mississippi[e]	12	75	2	(10)	(83)
Pennsylvania[d]	837	1,182	865	28	3
Texas[d]	1,353	1,712	1,551	198	15
Vermont[e]	65	16	5	(60)	(92)
Washington[e]	87	327	189	102	117
Total	$4,772	$5,333	$4,299	$ (473)	(10)
California[b]		$ 0	$ 0	$ 0	[c]
New York[d]		1,888	1,703	(185)	(10)
Total		$1,888	$1,703	$ (185)	(10)

[a]Period of change for first 11 states is 1981-83; for California and New York it is 1982-83.

[b]States reported they have consolidated their SSI and crippled children's services and reported SSI expenditures with crippled children's expenditures for one or more years.

[c]Percentage change cannot be calculated.

[d]States continued to provide a separate SSI program.

[e]States reported they have consolidated all or part of their SSI with crippled children's services, but continued to report at least part of their SSI expenditures separately.

APPENDIX XIV

EXPENDITURES FOR PROGRAMS AS A PERCENTAGE OF TOTAL EXPENDITURES

State	1981 Crippled Children	1981 Maternal & Child Health	1981 Other	1983 Crippled Children	1983 Maternal & Child Health	1983 Other
Colorado	28.9	63.5	7.5	28.5	61.1	10.4
Florida	46.0	49.1	4.9	53.3	44.6	2.1
Iowa	46.6	40.6	12.8	45.8	39.4	14.8
Kentucky	26.9	67.1	6.1	28.7	64.1	7.2
Massachusetts	26.2	54.1	19.6	32.9	48.3	18.8
Michigan	63.3	31.3	5.4	62.7	29.6	7.7
Mississippi	22.9	75.6	1.4	17.2	81.6	1.2
Pennsylvania	19.0	73.6	7.4	20.6	67.6	11.8
Texas	55.1	36.8	8.2	60.7	29.7	9.6
Vermont	18.1	73.1	8.8	19.1	76.8	4.1
Washington	36.6	55.5	7.9	43.5	47.2	9.3
Percentage of total MCH expenditures	39.0	53.7	7.3	43.2	48.7	8.1

State	1982 Crippled Children	1982 Maternal & Child Health	1982 Other	1983 Crippled Children	1983 Maternal & Child Health	1983 Other
California	68.8	25.0	6.3	66.0	26.9	7.1
New York	21.4	68.0	10.6	18.0	72.0	10.0
Percentage of total MCH expenditures	43.8	47.6	8.6	42.1	49.4	8.6

INTEREST GROUP RESPONSES TO QUESTIONS CONCERNING BLOCK GRANT IMPLEMENTATION FOR MCH PROGRAMS

Table 1
Change in Level of MCH Interest Group Activity

	Percent Increase	Percent Same	Percent Decrease	Number of Respondents
With state program official	45	47	8	193
With state legislature	43	50	7	189

Table 2
MCH Interest Group Satisfaction With State Methods of Facilitating Public Input Into MCH Decisions

	Percent Satisfied	Percent Dissatisfied	No. of Respondents
Hearings			
Time and location of hearings	55	23	171
Time allotted to block grants	52	21	155
Number of hearings	42	36	166
Degree of advance notice	44	43	185
Timing of hearings relative to states' decisionmaking process	33	52	163
Availability of information before hearings	30	52	170
Comments on state plans			
Length of comment period on state intended use plan	39	35	157
Timing of comment period relative to states' allocation decisionmaking process	36	46	154
Availability of state intended use plan	35	46	177
Opportunity to comment on revised plans	31	47	154

Advisory committees			
Composition of advisory groups	49	30	136
Role of advisory groups	45	33	141
Informal contact			
Accessibility of state officials for informal contact on block grants	65	14	166

Table 3
Degree of Satisfaction with State Responses to Issues of Great Concern to MCH Interest Groups

	Percent Satisfied	Percent Dissatisfied	Percent Neutral	Total No. of Respondents
Need to maintain or increase funding for specific services	44	44	12	133
Need to maintain or increase funding for protected groups [a]	44	48	9	94
Need to maintain or increase funding for geographic areas	33	47	20	75

[a]Does not total 100 percent due to rounding.

Table 4
Did Changes Made by States Have a Favorable or Adverse Effect on Individuals or Groups Represented by MCH Interest Groups?[a]

Percent Favorable	Percent Adverse	Percent Unsure/ No Effect	Total No. of Respondents
28	54	17	155

[a]Does not total 100 percent due to rounding.

APPENDIX XV

Table 5
Are Block Grants a More or Less Desirable Way of Funding MCH Programs Than Were Categorical Grants?

Percent More Desirable	Percent Equally Desirable	Percent Less Desirable	Total No. of Respondents
26	20	54	188

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